

COLUMBIA LIBRARIES OFFSITE  
HEALTH SCIENCES RESTRICTED



HR01206788

SERIAL

V. 4

J

1886

Columbia University  
in the City of New York  
College of Physicians and Surgeons



Reference Library











JOURNAL  
OF  
CUTANEOUS<sup>AND</sup> VENEREAL  
DISEASES

EDITED BY  
PRINCE A. MORROW, A.M., M.D.

---

VOLUME IV.

---

NEW YORK  
WILLIAM WOOD & COMPANY  
56 & 58 LAFAYETTE PLACE

1886

CONTRIBUTORS TO VOL. IV.:

ALLEN, CHARLES W.	MORISON, R. B.
ATKINSON, I. E.	MORROW, P. A.
BULKLEY, L. D.	OHMANN-DUMESNIL, A. H.
CORLETT, WM. T.	OTIS, F. N.
DUNN, JAMES H.	PALMER, E. R.
FOX, GEORGE H.	PIFFARD, H. G.
GOTTHEIL, WM. S.	PUTNAM, F. W.
GRAHAM, J. E.	SABIN, R. H.
HARDAWAY, W. A.	STELWAGON, H. W.
HYDE, J. N.	TAYLOR, R. W.
JACKSON, G. T.	TILDEN, G. H.
KEYES, E. L.	VIDAL, E. C.
KINNIER, D. F.	WESSINGER, J. A.
KNOCHE, J. P.	WHITE, J. B.





Digitized by the Internet Archive  
in 2014



*Dr. Jackson's case of Dyidrosis.*

JOURNAL  
OF  
CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

JANUARY, 1886.

No. 1.

---

Original Communications.

---

A CASE OF DYSIDROSIS OF THE FACE,

BY

GEORGE THOMAS JACKSON, M.D.,

Instructor in Dermatology in the New York Polyclinic.

ON the 13th August, 1885, Mrs. K., presented herself at the New York Polyclinic for treatment of a chronic eruption on the face. The following is a report of the case.

Mrs. K., born in Ireland; age 45; widow; cook. Her general health is excellent. She never has been sick a-bed a day in her life, excepting after parturition. She has had five children. During the past few weeks she has had some slight rheumatic pains in the knees and legs. She is stout, and her skin is soft and smooth. Her tongue is slightly coated, but otherwise there is no evidence of dyspepsia. Her bowels are regular, appetite good, and apparently she is in a good physical condition. Her present trouble began five years ago. It is worse in summer than in winter, and particularly when she is much over the fire, but *it has never been entirely absent* since it began. Except this present disorder she never has had any skin disease.

The eruption is located upon the face, occupying the lower half of the forehead, surrounding both orbits, occurring below both eyes, and on the sides and bridge of the nose, and running down on each side of the nose for a short distance on the upper lip. It has the appearance of large and small sago grains scattered over the affected parts, and consists

entirely of fully distended vesicles with clear contents. The largest vesicles are about the size of a split French pea, the smaller ones are of the size of a pin-head. They are generally discrete, though here and there closely crowded together. A few have apparently joined at their edges, and some of them are of a darker shade than the others. Central puncta are visible in a very few. When pricked, a clear fluid with acid reaction escapes from them. They do not rupture of themselves, and their covers offer considerable resistance to the lancet. The skin, otherwise, is perfectly normal, and free from any appearance of inflammation. When slightly rubbed with a handkerchief the skin becomes easily hyperæmic. There are a few dilated blood-vessels upon the nose.

The only subjective symptom is slight itching at times.

The diagnosis of this case lies between eczema, herpes, sudamina, and dysidrosis. At first glance eczema vesiculosum would naturally suggest itself. But eczema is a disease in which the vesicles tend to break down of themselves very soon after their formation, and to leave a moist exuding surface. Then, too, the vesicles of eczema are of pin-point to pin-head size, of pretty uniform dimensions in the patch, contain a clear watery fluid of alkaline reaction, show by the redness of the skin upon which they are seated their evident inflammatory origin; and the pruritus accompanying them is pronounced. The patches they form are of undetermined outline, with outlying vesicles in the neighborhood. So that in this case that diagnosis can be readily excluded.

In herpes, while the vesicles do not tend to rupture, they show a decided tendency to group themselves in well-defined patches. In herpes febrilis they are most commonly seen about the mouth and nose; in zoster they occur along the course of the branches of the trigeminus nerve, usually on one side of the face, and rarely symmetrically. In both forms of herpes there is more or less pain, of a burning character in herpes febrilis, and neuralgic in zoster. Both forms are very acute. The fluid in the vesicles is at first clear, later turbid, and always of alkaline reaction. These characteristics are so markedly different from what obtains in our case, that we may readily discard the diagnosis of herpes.

Between sudamina and dysidrosis the diagnosis is not so easy. The meaning of the term "dysidrosis" is difficult sweating. As the acid reaction of the fluid in the vesicles of our case pretty clearly indicates that the disease has a close relation with the secretion of sweat, and as, further, the disease is aggravated by exposure to heat, it would seem that dysidrosis would be an eminently correct name for the disease. But that name has been applied by Dr. Tilbury Fox in 1873, to a well-marked disease occurring upon the hands and feet, and in the literature of the subject I have been unable to find the record of any case in which it affected the face.



As described by Fox,<sup>1</sup> dysidrosis is an acute affection of the sweat glands and ducts which gives rise to an eruption of, at first, deep-seated vesicles upon the palmar surface of the hand, between the fingers, and upon their palmar surfaces. Soon the vesicles enlarge, and appear as sago-grain-like masses with, in many cases, a minute white speck in their centre, the opening of a sweat duct. In mild cases this may be the end of the process, and in a few days the whole disease may disappear with some slight scaling of the affected part. The disease is very itchy. It is not uncommonly met with. In more severe cases the vesicles become larger, and some may run together and form bullæ. The contents of the bullæ disappear by absorption and evaporation; their covers fall, and leave a reddened surface, which is dry. The reaction of the fluid of the vesicles is acid. Either of these forms may attack the feet, and not infrequently there will be a general eruption over the body of miliaria or lichen tropicus. The disease is induced or aggravated by excessive sweating, occurs in debilitated or nervous subjects, and is exceedingly apt to relapse. The whole process runs its course in a few weeks at the outside, often in ten days. Fox regards the disease as a neurosis, producing paresis of the sweat glands, and believes that the vesicles are produced by retention of sweat.

Crocker<sup>2</sup> made a number of sections of the diseased skin at various periods of its course, and reported the result of his investigation to the Pathological Society of London, in 1878; at the same time showing his drawings of the microscopical appearances. He found in the early stage of the eruption that there was no change in the horny layer of the skin, but there were loculi in the rete, and that these were interpapillary. The capillaries of the papillæ were apparently normal. The sweat ducts were very distinct in some sections throughout their course, and the sweat glands were apparently swollen and somewhat infiltrated. The capillaries of the corium, especially those that ran to and from the sweat apparatus, were here and there somewhat large and distended. The largest vesicles were formed by the coalescence of several smaller ones. The bullæ that formed were loculated. In no case were vesicles formed in connection with blood-vessels, or escape of fluid from them. He believes that, anatomically, the disease is an inflammatory affection of the sweat apparatus in which the ducts in the Malpighian layer probably became choked, certainly distended. This is followed by escape of fluid into the surrounding tissues, producing the characteristic vesiculations which are, at first, imbedded in the skin, and afterwards, in consequence of increase of the effusion, enlarge so as to cause an uplifting of the cuticle and the formation of loculated bullæ.

<sup>1</sup> Amer. Jour. Syph. and Derm., 1873, iv., 1.

<sup>2</sup> Trans. Path. Soc., London, 1878, xxix., 264.

Hutchinson,<sup>1</sup> in 1871, described the same disease in a clinical lecture, and called it "cheiro-pompholyx," a misnomer, as the disease occurs on other parts of the body besides the hands. He regards it as a neurosis occurring in nervous subjects, in no wise connected with the sweat apparatus, though in some cases produced by the action of high temperature.

Robinson<sup>2</sup> also described the disease in 1877 under the name of "pompholyx." He believes that the disease is a neurosis, and that the vesicles have an origin similar to those of herpes, especially of those of herpes progenitalis. From his study of the microscopical anatomy of the malady, he is led to hold that it has nothing to do with the sweat glands, and that the fluid of the vesicles is at first pure serum, coming from the papillary vessels, which, passing through and between the lower cells of the rete, collects in different situations to form the vesicles. He found the sweat glands to be normal, and their ducts were not distended. In one section the sweat duct was the principal structure separating two vesicles. The reaction of the fluid contents of the vesicles in his case, as in Hutchinson's, was alkaline.

When careful investigations by such competent observers give such opposite results, it is difficult to avoid the inference that they, perhaps, were studying different diseases. We cannot at present regard the matter as settled, and must await further studies in this direction.

Sudamina, sudamina crystallina, or miliaria crystallina, is an affection of the sweat glands, of non-inflammatory character, in which superficial, clear, dew-drop-like vesicles appear, which are of various sizes. The eruption is met with in many febrile diseases, in cachectic conditions in which excessive sweating takes place, and in some individuals, especially those who are fat or feeble, who are subject to profuse sweating from any cause. Its favorite locations are the face, chest, abdomen, axilla, and groin. Its duration is from a few days to two or three weeks. Robinson mentions a form of the disease which occurs especially on the nose, forehead, and cheeks of women, such as washerwomen who are exposed to the combined action of exercise and vapor. In this form we have a sago-grain-like eruption caused, as shown by microscopical examinations of sections, by retention of sweat in the sweat ducts in the corium, due to a stopping up of the duct by detached epithelium. The duct becomes enormously dilated. The facility of distention of the duct is aided by a loss of tone of its wall, consequent upon circulatory disturbances.

This form of sudamina has many anatomical features similar to those found by Crocker in the milder cases of Fox's dysidrosis, such as the dilatation of the sweat ducts, and the source of the fluid in the vesicles from the accumulation of sweat, and not from the blood-vessels. In their

<sup>1</sup> Lancet, 1876, i., 630.

<sup>2</sup> Archives of Derm., 1877, iii., 289.

symptoms they differ. The one has clear, dew-drop, prominent vesicles throughout its course, and is accompanied with very slight pruritus. The vesicles of the other are deep seated, are apt to develop into bullæ, and are very itchy. The one is located on the hands and feet. The other is peculiar to the face.

Our case certainly corresponds in its location, appearance, and etiology to the sudamina of the face of Robinson, and is doubtless the same disease. While exceedingly unwilling to introduce a new element of confusion into our already confused nomenclature, I have nevertheless chosen the designation of dysidrosis for our present case, because it is descriptive of the disease; a "difficult sweating" of the face. Dr. Robinson in the discussion of his paper on "Miliaria and Sudamina"<sup>1</sup> speaks of the condition as a true dysidrosis. For the "dysidrosis" of Fox, and the "cheiro-pompholyx" of Hutchinson, it would, perhaps, be well to adopt the name of "pompholyx," as suggested by Robinson.

---

#### CASE OF TYLOSIS (CALLOSITAS) OF THE HANDS.<sup>2</sup>

BY

ROBERT B. MORISON, M.D.,

Professor of Dermatology and Syphilis in the Baltimore Polyclinic.

**A**N unusual form of this disease presented itself at the Polyclinic in Baltimore last spring. In its way it was the most aggravated case I have ever seen, and in one particular it was unique, *i.e.*, in the entire absence of pain, notwithstanding the amount of surface involved and the ulcerations following.

The patient was a negro man, æt. 32, of dark complexion, well made, tall, very muscular, and apparently healthy. He was a fireman on a steamer running between two ports on the Chesapeake Bay. The trip was made in a day and night—the firemen working four hours on and four hours off. He had been ten years at this work, shovelling coal into a hot furnace with his left hand on the lower part of the handle of the shovel, and his right grasping its upper end. The result of this action was a constant rubbing of the palm and fingers of the left hand up and down the handle of the shovel, and a prolonged exposure to intense heat of both hands. He wore leather gloves made without fingers, but which covered the palm and thumb of each hand, thereby protecting them to a slight de-

<sup>1</sup>Trans. American Derm. Asso., 1884.

<sup>2</sup>Read before the American Dermatological Association, August 27, 1885.

gree. The constant friction to which they were thus exposed gradually changed the whole contour of the left, and partly of the right hand. All the fingers of the left hand were affected. Two of them were actually worn off as far as the second joint, while the other two were gradually going in the same way, their nails having almost disappeared. The two entirely worn off presented the appearance of an onion cut into halves. There was a series of layers of thick, hard, lifeless epidermis arranged in concentric circles from the centre outwards. In the centre the sharp end of a piece of bone was visible. The man said he had only a few days previous picked out a piece of bone nearly an inch long from one finger and thrown it away. He felt absolutely no pain when he did so, nor had he suffered any from the fingers in which the disease had not progressed far enough to affect the bone. Several months before, a piece of bone from the other finger had been removed by a surgeon in a hospital, but the time he lost in healing the finger after the operation was the reason why he performed the second operation himself. After throwing the end of his finger into the fire, he continued his work, not even taking the trouble to dress the wound.

On the palm and in some other places besides the ends of his fingers, there were the same spots of hardened, thickened epidermis arranged in the same circular layers. On his left hand, where the inside of the thumb rubbed up and down the handle of the shovel, there was a large ulceration the size of a quarter dollar, from which he had picked the epidermis. Underneath was a raw, red, indolently granulating surface which was painless, and consequently he went on with his work rubbing the spot with the shovel as diligently as ever.

Such ulcerations in other places he had often had before on the hands and fingers, and they either healed over leaving a pigmented, smooth scar, the epidermis of which resembled that seen in ordinary callosities, or else they closed in gradually from the periphery, the epidermis piling itself up in layers over them, until they formed one of the spots already described.

The ulceration on the inside of the thumb, however, did not terminate in this manner. It went on granulating and being rubbed for a week, when the tissues became so thin, the ends of both bones of the first thumb joint could be plainly seen. In another week the bones were perfectly bare, they had become black—in other words, necrosed—and the man was waiting for them to drop out. Meanwhile, as the thumb was much weakened and the control of the joint was imperfect, the man had applied two splints of wood long enough to more than cover the joint on the upper and under surface of it. In this way the thumb was strengthened and was rendered, as he said, less “wobberly.”<sup>1</sup> Thus he went on

<sup>1</sup> The plates were kindly drawn and colored by my assistant, Dr. Keyser.



with his work almost as well as ever, nor was there any pain in either hand. He said he would not give up his work as long as he could handle a shovel because, firstly, he made more money at it than in any other way, and secondly, he would be pensioned if disabled.

I could obtain no plain history of syphilis from him, nor could I find any signs of it, such as scars or enlarged glands, upon his body, although he told me he had been given antisyphilitic remedies because other physicians thought the condition of his hands due to that disease. In this I could not concur, especially as the treatment was useless.

I gave him a pair of india-rubber gloves to wear while working, which softened to a degree the callosities, but which were not beneficial to the ulcerations. Recognizing the fact that, as long as the irritating cause continued, there was no chance of cure, he was advised to that effect, and told to return for treatment when he could take a long rest. He has only been seen once in many months, and that was a week ago. He was still at work, his hands getting worse.

The absence of any pain in the course of the disease, and the well-known indifference to the future of the African race were elements in the case which it was useless to contend with, especially as it could be easily seen that he was one of the easiest-going, happiest, good-humored darkies in the world, who could even grin while he picked out the bones of his fingers to throw them away.

It is not my purpose to discuss minutely the causes and treatment of such a common trouble. The interest in the case lies chiefly in the amount of destruction of tissue gradually superinduced by external causes, and in the indifference to the surely increasing demolition of his hands which the patient stoically exhibited.

In ordinary cases of callosity without ulceration, pain does not enter into the consideration of the disease, as it is seldom present; but its absence with ulceration and abscesses is rare, even in the negro.

The consideration of this point, and to call attention to another source of error which leads many physicians to refer every skin disease to syphilis, is my excuse for presenting this short paper.

November 1, 1885.—Since reading the history of the above case in August last, the patient has presented himself again at the dispensary (Oct. 23) with the following changes. All the fingers have healed. There are no callous spots on either hand. The thumb of the left hand where the bones of the joint were exposed, still has a healthy nail, but is half an inch shorter than formerly. It looks as if it had been telescoped backwards, for it has only one remaining joint.

The skin of both hands is healthy-looking, and the left hand, as a whole, appears like a congenital malformation where the fingers have never developed. The man is still at work as a fireman, and his only

treatment has been the wearing of the india-rubber mittens turned wrong side out—the india-rubber coming next the skin—and an ointment of salicylic acid, five per cent, in vaseline. He has taken no rest.

The result obtained by this treatment, although quite unexpected—vide prognosis above—seems to still further justify the opinion that the mechanical injury and the constant exposure to intense heat, which in one sense is traumatic in its effects, were the causes of the trouble.

If it had been neurotic in origin, or a disease of the skin *per se*, the simple protection of the parts would not have resulted so satisfactorily. In a healthy man, any sort of ulceration will speedily tend to recover if non irritated. The surprisingly good result in this case encourages us to believe that by mechanical protection we may, more frequently than is thought, counterbalance mechanical irritation.

---

#### SOME OF THE USES OF PYROGALLIC ACID IN DERMATOLOGY, AND THE DANGERS ATTENDING ITS APPLICATION.<sup>1</sup>

BY

CHARLES W. ALLEN, M.D.,  
Surgeon to Charity Hospital.

**A**BOUT seven years ago, Jarisch, of Vienna, introduced pyrogallie acid to the medical profession, especially as a substitute for chrysophanic acid in the treatment of psoriasis, and it has since been used in a variety of skin lesions with much success by many dermatologists. At times its application has been followed by poisonous effects, and for this or other reason, after making a trial of the drug, some have given up its use.

It was the writer's good fortune to pass a year in Vienna just after the introduction of this then new remedy, and to see its use extended by Kaposi and Neumann to the treatment of lupus and epithelioma. Many cases of these diseases as well as of psoriasis were treated at the clinic that year, the ten-per-cent ointment with vaseline, as recommended by Jarisch, being generally used.

As regards the treatment of lupus, we have such high authority as Schwimmer, of Budapest, and Besnier, of Paris, for saying that in pyrogallie acid we possess one of the most useful means of treatment. Probably no one has had a more extended experience with this acid than has

<sup>1</sup> Abstract of a thesis read before the New York Dermatological Society, Oct. 27, 1885.

Besnier. He began using it immediately after its introduction into medicine, and has since continued to make extensive use of it. He regarded it three years ago as superior to all other local applications in the treatment of psoriasis.

With reference to its employment in lupus, Besnier says, in the *Annales de Dermatologie et de Syphiligraphie*, January, 1885, that pyrogallic acid produces perfectly the desired action of provoking a suppurative dermatitis. And especially can it be resorted to in those very old cases of lupus, and very extensive ones, which have already been mutilated, and are refractory, in a measure, to all treatment. He advises a saturated solution of the acid in ether, to be brushed over the diseased surfaces, or a spray of the same applied. This he covers at once with a layer of "traumaticine." The applications are to be repeated until all lupus points have disappeared from the cicatrix.

He considers this the least painful and the most expeditious plan of treatment that he has found, especially for the varied forms of Willan's lupus.

Schwimmer presents his views on his method of treatment in the *Wiener Med. Wochenschrift*, XXXIV., 20-22. To prevent the return of tubercles in the cicatrix (which is a common occurrence after the apparent cure of the disease), he employs emplastrum hydrargyri to promote the absorption and complete the cure.

The application is made as follows: Vaseline is first applied for several days, or as long as necessary to remove all secondary morbid products, scales, secretions, and dirt, a ten-per-cent pyrogallic ointment is then applied during from four to seven days, being renewed two or three times daily. Vaseline is now to be applied again for one day to remove all of the acid. The entire suppurating surface is now to be covered with the mercurial plaster, under which healing takes place in from ten days to two weeks. This process may be gone through with several times until no more tubercles appear. Prof. Schwimmer says the treatment of a case seldom exceeds three or four months. A speedier and much better resolution of the most advanced and wide-spreading lesions are found to take place under this combined plan of treatment than could be accomplished by the combined treatment of scarification and the thermo-cautery.

He considers the combined method especially indicated in the most extended forms of lupus, and in the neglected and untreated cases. Relapses may occur as after other plans of procedure, but are least to be expected when the treatment has been thorough.

My own experience with pyrogallic in lupus, although quite limited, has been very favorable. Many of the cases met with are extremely obstinate and rebellious to any treatment, and progress or recur in spite

of well-directed effort. Again many of the methods of treatment are exceedingly painful, and although that by pyrogallie may be made so, and at times is so, notwithstanding our desire to secure the result with the minimum amount of pain, still it must be regarded as a comparatively painless procedure.

In cases where the disease has returned in the cicatrix of a patch previously scraped, burned, or treated in some other way, this method has appeared to me to be of especial value. The acid seeks out, so to speak, the individual tubercles or nodules of the disease, and determines a destructive ulceration in and about them, leaving the healthy tissues unchanged. I have seen such a scar appear quite sieve-like or worm-eaten after a few days' application of a pyrogallie ointment, and then heal up nicely and quickly under a zinc-oxide ointment.

Cases I., II., III., and IV. omitted for want of space.

The following case was sent to me by a physician for treatment just one year ago.

CASE V.—Mrs. D., Newburgh, N. Y., æt. 64, presented herself at my office on May 31, 1884, with an extensive lupus vulgaris of the nose, which she says began nine years ago, on the bridge of the nose, where the eye-glasses made pressure. Her family history indicates marked tendency to scrofulous affections. The previous history is that, after measles, she was much troubled, for a long time, with an affection of the eyes and ears, and had glandular enlargements in the neck, which became ulcerated, and have left characteristic scars. While young, patient always had acne, and during her whole life has had more or less eczema of the ears. I may mention as having a bearing on the case that the lady's daughter has been treated by me for acne and a generalized psoriasis.

When I first saw the case, the disease extended from above the eyebrows down over the nose to within about half an inch of its tip, extending on either side almost to the inner canthus of the eyes, and spreading out slightly upon the cheeks. The ulcerated surface, which was covered with a thick, dirty crust, formed a triangle, inclosing a cicatrix which was thin and tensely stretched over the bridge of the nose. The patient states that the disease has gradually extended, notwithstanding a great variety of applications, caustics, blood-purifiers, teas, Indian remedies, quack preparations, and the treatment, from time to time, of regular physicians. The nose has never been entirely healed since it first became ulcerated, and having given up all hope of its ever being cured, she has had no treatment recently.

The tubercular infiltration, consisting of soft subcutaneous, reddish-brown papules, having, however, encroached upon the eyes, and already invaded the upper lids, she now again seeks relief. She objects strenuously to any operation or painful application, and says she will be satisfied if the progress of the disease in the direction of the eyes can be arrested, no matter how long a time is required. I did not promise to accomplish this result, if restricted in the choice of method, but decided that pyrogallie offered the best means in such a case. After applying vaseline to remove all crusts and prepare the ulceration, I began dusting powdered pyrogallie



acid upon the right side of the nose on June 14, and continued it daily, or every second or third day. In the mean time, an ointment of equal parts of emplastr. hydrargyri and ung. diachyli was kept constantly applied to the left side. By June 28, the right side had greatly improved, but the left had remained in *statu quo*. The powder was now applied to the lower third of the ulceration on the left side. A ten-per-cent ointment was employed in the intervals between the applications of the powder during a portion of this time. On August 18, some new lupus nodules, which were encroaching on the canthus on either side, were scraped out, and the acid was now applied to the whole surface. The accompanying cut, from a photograph taken at this time, shows the condi-



tion, a portion of the right side being healed. This treatment was, in the main, followed out. She was given, at different times, iodine, iron and malt extract, but never continued any internal remedy long enough to affect the disease to any great extent. In the latter part of November, I stopped applying the powder to the slight ulceration which remained, and used, for eight days, a thirty-grain-to-the-ounce ointment, followed by emplastr. hydrarg. for two weeks, as recommended by Schwimmer. I found this to hasten the curative process materially. On December 10, the nose was to all intents well. The cicatrix was pliable, without any sign of tubercle remaining or forming in it. On December 16, patient returned to her home, much gratified at the result, and, so far as I know, has continued well.

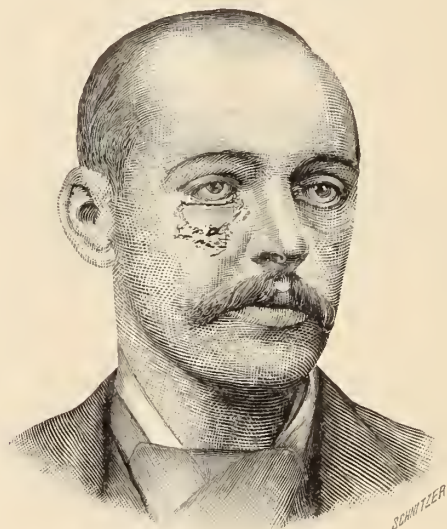
Whenever lupus tubercles are not encountered, the action of pyro-

gallic acid is, as a rule, quite superficial. Besnier says that lupus erythematosus is less benefited than the other form unless it is of a very superficial variety. I will relate the following case of lupus erythematosus treated by the acid :

CASE VI.—Mrs. A., of South Carolina, came to consult me, on August 27, 1884, in regard to a red spot on the end of the nose, which had begun four years before as a small pimple, and had increased slowly in size, occasionally becoming somewhat scaly. It measured about one centimetre in diameter. The centre was covered with an adherent crust, where a slight ulceration had recently taken place. I removed the crust and applied powdered pyrogallic acid, and furnished her with the powder to continue the treatment, when she was about returning to her home. On November 13, she wrote me that the disease was spreading, and rather worse. I now ordered a five-per-cent ointment, to be followed by mercurial plaster (Schwimmer's method). At Christmas time, she sent word that the spot had entirely healed, and that the disease was, to all appearances, cured.

I have at the present time two cases of lupus vulgaris under treatment.

CASE VII.—James C., Ireland, age 30, presented himself on August 19, 1884. He had upon the right cheek a patch of lupus, extending



from the margin of the lower eyelid down upon the cheek. The lower half of the patch, measuring about one and a half inches in either diameter, was ulcerated and elevated above the surrounding skin, standing out an eighth of an inch or more from the surface. The tissue composing this mass was yellowish in color, and although of firm consistence, easily

breaking down; it continually discharged a yellow-colored fluid. A deep sulcus occupied the whole length of the lower lid, just beneath the line of the lashes, all of which had been destroyed. At the inner canthus the disease had extended upon the mucous surface of the lid. This condition had produced a marked ectropion, and the eye was kept constantly irritated. The disease first began as a papule under the skin of the cheek, nine years ago, and gradually extended.

For five years patient states he was under continuous treatment, without the process being entirely arrested. For some time before he came under my observation, the disease had been neglected. I removed the tissues which projected above the surface with the knife, and after removing all crusts, applied powdered pyrogallic acid to the whole surface, and repeated the application almost daily. By September 1, the sulcus of the lid had healed almost to the inner canthus, and by September 20, the entire patch was healed, excepting a small ulcerated surface at the inner canthus of the eye, where the disease still extended upon the conjunctival surface. Finally, this, too, healed perfectly under the powder, and the patient stated that the face had never been so well since it first became ulcerated.

As I had anticipated, the cicatrix became nodular after a time, and the disease began to show itself at several points. I now scraped out all the nodules which would break down under the sharp spoon, and reapplied the powder, renewing it as often as the crusts, which formed after its use, could be removed without violence. Again a fairly good cicatrix was formed, but I now took the precaution to order mercurial plaster to be constantly applied. After being absent, and without due care for some time, patient applied again for treatment, about the first of May. At the lower edge of the cicatrix there were two small circular ulcers, having elevated firm edges, with some papules or nodules in their neighborhood. At the external canthus of the eye, this time, we find an ulceration, and as the lid is everted, a whitish wart-like mass is seen projecting inward from it, similar to that which existed on the cheek when first seen. Another infiltrated mass, slightly ulcerated, and also extending well upon the inner surface of the lid, existed at about its central part. These ulcers of the lid have since been treated with the powder. The larger ulcerations were treated for a week with ointment, in the strength of a drachm of pyrogallic to the ounce, followed by emplastrum hydrarg. until May 12, when the powder was substituted, as little improvement had taken place. The pyrogallic ointment was also applied again, and changed two or three times daily until the 17th, when a deep ulceration had occurred. I now covered the lesions with a ten-percent solution of pyrogallic in collodium, for five days, when the tissues appeared healthy, and the emplastrum hydrarg. was again ordered.

This has since been kept up. On June 6, a fine cicatrix had been formed, and the infiltration of lupus tissue was so slight at the edge of the lid that the patient considered himself cured.

About the end of July I heard indirectly from this case that it was remaining well.

CASE VIII.—John D., native of Ireland, age 45, came to the University dispensary on March 2. He presented a patch of lupus vulgaris,

high up on the forehead, about three centimetres in diameter. He stated that it had begun before his eighteenth year, and had been without treatment to speak of until last summer, when caustics caused the central portion to slough out. One portion of the patch is now ulcerated and covered with a crust. I applied for four days equal parts of unguentum hydrargyri and adeps, which softened the tissues somewhat and caused slight ulceration at several points. I now applied a ten-per-cent pyrogallic ointment for a week or ten days, and followed it by the mercurial plaster for two weeks. This process has been repeated several times, and when last seen, after about two months' treatment, the ulcerated surface which had been produced was granulating, and gave reason to anticipate a good result.

As Schwimmer says, it is probable that in lupus the total destruction of the infiltration is rarely possible by the agency of pyrogallic acid alone. It does in some instances destroy the infiltrated cells and lupus nodules in a remarkably short time, and the resulting cicatrix may appear quite free from the morbid growth; but, sooner or later, new points of disease are apt to appear either in the cicatrix or at its margin.

This limit to the beneficial action of pyrogallic is not true of lupus alone, but appears to be a general characteristic of its action. Vidal found that up to a certain point only did the acid exercise a beneficial action on chancreoids, and he advised completing the cure with iodoform.

Vidal was the first to make use of the drug in soft chancre, and after an extended trial of its merits, reported such success with it that he was followed by Terillon, who applied it to all cases of ulcerating chancreoids coming into his service at the Lourcine Hospital during a period of three months. At the same time, Mauriac was experimenting with the drug at l'Hôpital du Midi, and obtaining very favorable results. The mode of application was chiefly in form of ointment, but Vidal also recommended a powder with starch, one to four. The pain caused by these applications amounts to nothing as compared with that caused by the various applications so much in vogue in chancreoid. I find the pain caused by the pure acid is only momentary and not severe in these cases, and I prefer to dust the sore thoroughly the first day with the pure powder. The following day, after removing any crusts, I apply a collodion dressing containing ten per cent of pyrogallic.

After a few days, a healthy action will be established, and iodoform, black-wash, or other dressing will be sufficient for the after-treatment.

Ointments are always uncleanly, and to me unsatisfactory dressings for venereal sores. A well-made fixed dressing which will adhere to the parts is much to be preferred.

Pyrogallic acid, I believe, will be found useful in a variety of skin lesions to which it has as yet not been extensively applied. In the following case, I obtained a good result with it after all other means employed had failed.



CASE IX.—Miss C. came to me on Feb. 1, 1884, suffering from tylosis of the feet and a fungous, or more properly, a villous growth, having a diameter of about two and one-half centimetres in the centre of the right heel, which had resulted in some way from the thickened epidermis of the sole, and had existed for over a year. It had given her great annoyance, preventing walking except with much pain, and had obstinately persisted in spite of all remedies. A sulcus running down into the corium encircled the base of the growth. The patient refusing to permit me to scrape out the diseased tissue, I consented to try other means. For six months I made every effort to effect a cure. I removed the masses of thickened epidermis surrounding it, and applied in turn nitric acid, carbolic, nitrate of silver, ointments of red precipitate, of salicylic, diachylon, and a variety of others. I applied various fixed dressings, medicated collodions, etc., but all to no purpose. Improvement only took place for a brief period. I now applied pyrogallie in liquid gutta-percha, a drachm to the ounce. Within a month, great improvement had taken place, and by January 19, it was apparently cured. In March, however, the heel swelled up, became tender, suppurated, and left an ulcerated surface. The traumaticine and pyrogallie acid were again applied, under which healing took place by April 18, since which date it has remained perfectly well.

The dangers attending the use of this agent which we have been considering are twofold. That is to say, they not only have reference to the constitutional poisonous effects at times observed, but also to the local injuries occasionally met with. So far as I am aware, no severe cases of poisoning from the external application of the drug have been reported in this country, nor have I seen any account of its injurious effects upon the tissues locally. I desire more especially to call attention to the harm it is capable of doing to the healthy skin, but as the subject has not received much attention in our country, I may be pardoned if I run over the cases in which poisonous symptoms and even fatal results have followed its use.

All who employ the comparatively new remedy should keep in mind these possibilities so as to guard against the occurrence of poisoning, and by recognizing the earliest symptoms be able to apply at once the proper remedies.

Just after its introduction into dermatology, Neisser published, in the *Zeitschrift für Klinische Medicin*, an account of a fatal case of poisoning by the drug following a single application of a ten-per-cent ointment. The patient was a strong, healthy man, aged 34, who came to the clinic at Breslau to be treated for psoriasis. On the night of his admission, after a vigorous friction with the ointment, which caused some burning, he was attacked with shivering, had three or four diarrhoeal stools, and vomiting of a glairy mucus. The next day the same symptoms continued. The skin assumed a greenish-brown hue. There was a continuous tremor of the lower jaw. The following day the patient was in a

state of collapse, and on the morning of the fifth day he died in coma, after a train of symptoms to which we will again refer.

The urine passed during the last two days showed the most marked form of hæmoglobinuria. The color was dark-brown, with a greenish tinge to the topmost layers. Its reaction was acid. Specific gravity 1.014, and the spectroscope showed the characteristic lines of hæmoglobin. At about this same time (1878), Vidal had the misfortune to lose a patient 18 years of age, who was under his care at the St. Louis. He was being treated for a psoriasis of two years' standing, with a one-to-ten pyrogallie ointment, which the patient applied himself to the whole body. About the fifteenth day, after using more than he had been instructed to do, vomiting and diarrhœa suddenly came on, hæmaturia and anasarca, attended with dyspnœa, rapidly developed, and death ended the scene some fifteen days later.

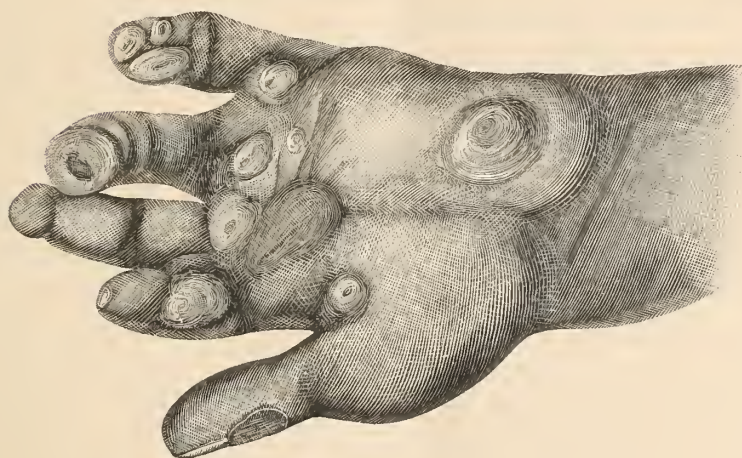
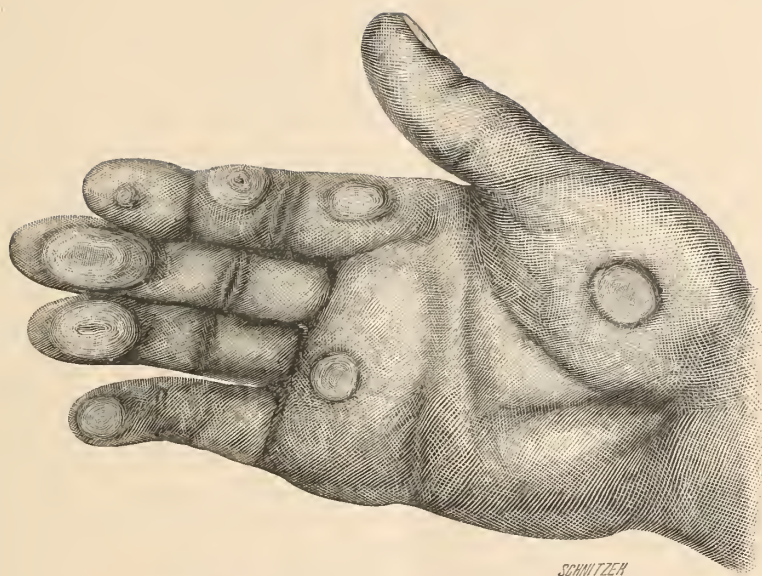
Up to this time, Besnier had repeatedly applied ointments containing as much as twenty-five per cent of the acid to the whole body. Now, however, warned of its dangers, he reduced the percentage to ten, and even five, and began to watch his cases more closely. Three years passed, and no evil results other than an occasional erythematous-vesicular eruption followed the use of the drug. Suddenly a patient who had entered the St. Louis with a generalized psoriasis of seven years' standing showed symptoms of poisoning after three frictions with the five-per-cent ointment. This patient was also a strong, vigorous man, still his symptoms were so profound that on the fourth day he was apparently dying. It was only after the most vigorous treatment with sinapisms to the whole surface, hypodermic injections of ether, inhalations of oxygen, and the administration of alcohol, all many times repeated, that his life was saved.

The following case was reported by Besnier, to whom it had been communicated by Piek, of Prague. On January 1, 1881, an otherwise healthy servant girl, aged 27, was ordered a ten-per-cent pyrogallie ointment to be applied to a psoriasis. It was rubbed into a different region of the body each day until January 7, when a marked inflammatory action was noted. The applications were renewed, however, on the succeeding day, and towards evening the girl complained of a headache and general malaise, subsequently rigors, vomiting, and temperature rising to 40° C. were noted. After a night of great restlessness and excitement with burning thirst, the urine having a sp. gr. of 1.030, was found bloody, containing hyaline casts, and giving the spectra of hæmoglobin. The patient was put into a wet pack, which produced diuresis and abundant diaphoresis.

Albumin remained in the urine for three days. Patient was finally discharged cured.



Journal of Cutaneous  
and  
Venereal Diseases,  
January, 1886.



Dr. Morison's case of Tylosis (Callositas).



Reviewing these cases, which, so far as I am aware, are all that have been reported, although presumably not the only ones which have occurred, what have we to learn from them?

The facts furnish proof that the drug is at times dangerous, and may be even fatal, and that the poisonous effects can be produced by absorption through the skin. They would also appear to show that an idiosyncrasy or personal predisposition must exist for the drug, as only here and there one is affected from the same strength of application, and in one case a fatal result followed a single application. Still, on the other hand, the tardy poisonous effects, only showing themselves after the use of the ointment for a considerable time, is not what we should expect where this idiosyncrasy exists.

The weak and sickly do not appear to be so easily affected as the strong and robust. In every case mentioned, we are impressed with the fact that the subject was a vigorous, healthy individual. We learn also from these cases that it is not safe to practise frictions over too extended a surface at a time, and that a mild ointment should be used, especially in new cases. Besnier says that not over five grams should be used in the twenty-four hours. The effects caused by its absorption are probably due to the great affinity of the drug for oxygen, or as the pyrogallie oxidizes into carbon monoxide, carbon dioxide, acetic acid, and probably other substances, these same reactions may take place within the economy, in the presence of the alkaline blood, and the toxic effects be due in a measure to them, as well as to the abstraction of oxygen, and it is indeed to the removal of oxygen from the blood that many of the symptoms may be referred. Personne says that the effects produced are the same as in poisoning by phosphorus, and it is, in a measure at least, due to its deoxidizing properties that the injurious effects of phosphorus are due.

The principal symptoms found in these cases are: chill, rigors, or shivering, preceded possibly by malaise and headache, and coming on rather suddenly, at a variable time from the beginning of the applications. There are usually diarrhœal stools and vomiting of glairy mucus. The patient soon sinks into a state of collapse with sunken eyes, pallid or cyanosed appearance of the lips, a peculiar greenish hue of the skin, elevation of the pulse-beat and temperature, and acceleration of respiration with dyspnœa. The urine becomes dark-brown or black, of high specific gravity, and usually contains hæmoglobin and albumin. The reflexes are diminished. In the early stages there is marked insomnia and restlessness. Toward the close there may be coma. The dyspnœa is due to pulmonary œdema and congestion of the lungs. There may be a condition of general anasarca.

The symptoms persist only so long as the poison is being eliminated,

and when this has been accomplished, convalescence is good and rapid, provided the patient's strength be maintained. In these four cases we find two deaths and two recoveries.

As to treatment; that adopted by Besnier, in the case in which the patient's life was saved after being despaired of, appears rational. He was led to make use of the oxygen inhalations by the brilliant results obtained from it in the intoxication from carbon dioxide, in true asphyxia, and in malignant syphilis. He looks upon the vomiting and diarrhoea as salutary, and does not advise their being checked.

I desire now to call attention to the injurious effects at times produced by pyrogallic acid on the tissues to which it is applied. So far as I have been able to learn, no one has pointed out the dangers to which the healthy skin is subjected, further than to mention that a dermatitis or erythema may at times be produced. Authors state that the healthy skin is not affected; that in lupus, for example, the acids acts only on the lupoid tissue, destroying the nodules of the disease, leaving the adjacent skin uninjured. Now this is true to a very great extent, but I have been made disagreeably aware of the fact that the action of the drug does at times overstep the bounds of the disease, and cause serious injury to healthy parts.

I will illustrate with two cases which have recently been observed by me.

CASE X.—Lucy G., æt. 12, presented herself on November 10, 1884, for the treatment of psoriasis, which occupied the parietal region of the scalp on either side, and an area on the right thigh, the size of the palm. A ten-per-cent pyrogallic ointment was ordered. During the first week there was marked improvement. Upon her third visit about a week later, the tissues for an inch beyond the edge of the plaque and the diseased area itself were blackened and charred, and the skin of the thigh much inflamed for some distance about. She had suffered much pain, and walked with difficulty. The ointment was discontinued, the thigh cleaned of any ointment remaining upon it, and a zinc-oxide ointment substituted. There developed an ulceration of the healthy skin about the patch which did not heal until some time in December. By February 1, when she was last seen, the skin had almost regained a normal condition, but was still of a dark-red hue and somewhat pigmented.

CASE XI.—Jas. G., æt. 28, presented himself on November 24, 1884, with psoriasis affecting the hairy scalp and forehead. There existed also on the right leg a patch of the disease about two and a half inches in diameter. I prescribed an ointment of naphthol for the scalp, and a ten-per-cent pyrogallic ointment in vaseline for the leg. This was applied for about a week, when the patch became black and hardened, and the skin for about an inch beyond blistered, and presented the appearance of a burn. Soothing applications (simple cerate or vaseline) were applied. By January 3, the charred tissues had sloughed off, leaving an ulcerated surface twice the size of the original psoriatic patch. This, in healing, left a disfiguring cicatrix, with bands radiating from



the centre to the periphery, resembling the spokes of a wheel. The patient expressed himself as being entirely satisfied with the result, since the diseased patch had been destroyed. To me, however, it was not at all satisfactory, and I could only congratulate myself that the scar was not upon a more exposed region of the body.

I could find no satisfactory explanation for the violent action of the ointment in these cases. I was using almost daily the same strength in vaseline and simple cerate, put up by the same druggist, without noticing any other bad results. I have, however, in several instances of lupus and epithelioma, seen strong applications destroy an area of cicatricial tissue which was apparently free from nodules or infiltration of the disease.

As a rule, no ill result is to be anticipated from the application of the drug to the healthy tissues, and so little effect does it usually have, that I have applied the powder to the conjunctiva a number of times without producing more than a transient burning sensation.

Occasionally, after using pyrogallic acid for some time, much pain is complained of, and the tissues become inflamed. It is always well in this event to cease its application for a time and substitute some bland ointment.

In preparing any application of pyrogallic acid, care should be exercised to avoid any combination with an alkali, which would neutralize it, and any combination with a metal which it would reduce. Vaseline, being neutral and not subject to any reactions with pyrogallic acid, has appeared to furnish an excipient free from all objections. Its penetrating power is, however, not great, and on this account an animal fat is at times preferable. Owing to the de-oxidizing power of the acid, these fats readily decompose and produce irritating bodies, and indeed it is due to this fact that an irritation of the healthy skin takes place at times, after continued applications. When, therefore, animal fats are made use of, the ointment should be prepared only in small quantities and only used while fresh.

Aside from the use of the powdered drug in full strength, and of the five and ten-per-cent ointment, I have employed at times the various combinations of pyrogallic acid with gelatin, collodion, and gutta-percha, which of late years have been recommended, and which are now prepared and placed upon the market by a number of firms. In many cases they are greatly to be preferred to other applications, having the advantage over them of cleanliness, ease of application, a certain amount of pressure exercised and support given to the tissues, etc. The application of the powdered pyrogallic acid causes, occasionally, thick crusts to form, which may become irritating to the tissues and which at times are not easily removed.

I have had successful results in psoriasis and other affections, from the employment of a collodion containing about forty grains of pyrogallie acid to the ounce, and the addition of eight or ten drops of castor oil.

This forms an excellent dressing for lesions about the face and other exposed parts. When first applied to a raw surface, some pain is experienced, but this soon passes away. It had seemed to me that from these fixed dressings only a slight effect of the drug could be obtained, but I have been surprised at times to see how marked an effect is produced by them.

To procure, however, a powerful and speedy result, it has appeared to me well at all times to apply the powder to the lesions, and after drying of all secretions, to paint over a medicated collodion or traumaticine.

In conclusion, then, we find that in pyrogallie acid we have a drug valuable, not only in psoriasis, for the treatment of which affection it was first introduced, but furnishing one of the means of combating other and more serious diseases.

That its application is not without dangers both to the general system and to the body's healthy surface. That it is capable of producing death in the one case, and extensive sloughing in the other. That although the application of the drug in its full strength as a powder is efficacious, it is attended with some disadvantages. The crystals should be powdered before being applied.

For many cases a well-made fixed dressing, which adheres nicely to the part, possesses advantages which make it preferable to other applications. This is especially true of lesions of the face and hands.

The intensity of the effect produced appears to be in a measure proportionate to the thickness of the layer of fixed dressing painted upon the parts.

---

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

158TH REGULAR MEETING, NOVEMBER 24, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. ROBINSON presented a

#### CASE OF LICHEN PLANUS.

John S., 30 years. First noticed eruption on scrotum fifteen years ago, and has never been free from it in that situation since. He did not notice the lesion elsewhere until three or four months ago. Now the entire scrotum is covered with



a number of papules; some of them are isolated, others have coalesced, forming large patches. On the left side of the penis are a number of papules, forming a ringed appearance, resembling somewhat a *tinea circinata*; in this situation, the lesion appears to spread peripherically, and heal more or less in the centre. On the right ankle are several papules, some isolated and discrete, while others have coalesced. There are also some papules in the right popliteal space. These papules are flat and shiny, and present all the appearances of lichen planus, the peculiar feature in the case being the coalescence in many places of the papules. The eruption itches greatly in damp and cold weather; this is relieved by the application of very hot water. The patient has always enjoyed good health, with the exception of occasional attacks of rheumatism.

DR. MORROW said that the case was a very interesting one in the mode of its distribution, and also in the apparently stationary character of the lesions. He had watched many cases, but had never seen one in which it took more than three or four months for the complete evolution of a papule. He had serious doubts as to whether any individual papules remained fifteen years; if so, it was quite remarkable. He thought that the crescents and segments were formed by the coalescence of separate papules, and not by peripheral extension, with healing in the centre of individual papules.

DR. TAYLOR had seen instances where these segments and circles resulted from the coalescence of the papules, but he had never seen them formed by the clearing up of patches in the centre and their extension peripherically.

DR. FOX said that he had made a careful study of the different varieties of lichen planus, and had called attention to three distinct forms of the disease. In the first form the papules have a depressed centre with an angular outline, and appear generally on the arms and forearms; this is the form described by Wilson, he (Dr. Fox) spoke of it as the lenticular in contradistinction to the miliary, and a third variety caused by the fusing or coalescence of miliary papules producing the annular form. In the latter variety he believed that the patches increase in size by the growth of new papules. He thought that fifteen years was a long time for a papule to remain, and believed that new ones were constantly being formed. He had seen cases benefited by the application of a strong solution of pure carbolic acid which stopped the itching. He had also used Unna's ointment containing a strong solution of bichloride of mercury.

DR. SHERWELL said that most of his cases had occurred in persons broken down in health. He generally gave tonics, and mainly arsenic, to build them up. Some of the lesions would disappear without treatment. Locally he used a lotion of bichloride of mercury, dilute hydrocyanic acid, and emulsion of bitter almonds to allay the irritation.

DR. JACKSON mentioned two cases which he had treated with Unna's ointment with remarkable success.

DR. KEYES remembered a gouty family where two members had lichen planus in the same year, which disappeared under treatment, to return again on the hands the following year, it again disappeared and did not return again. In these cases the treatment was mainly alkaline.

DR. TAYLOR, when at Bellevue Hospital, had obtained good results from the use of the following ointment:  $\mathcal{R}$  Olei rusci, vel Olei cadini, 3 i.; Ungt. hydrarg., 3 ij.; Ungt. simplicis,  $\mathcal{S}$  i.; M. ft. ungt.

DR. MORROW had two cases under observation several years ago: one was a woman who had rheumatism; he gave alkaline diuretics, and used sedative lotions; she recovered in a few months. The next case got well in about the same time without treatment, so he concluded that in some cases, at least, the lesions disappeared spontaneously.

DR. BRONSON wished to say a few words in reference to treatment and especially the use of carbolic acid; he had employed it in solution in the proportion of two drachms to the ounce. Internally he used various remedies, more particularly mercurials, and he recalled one case where the lesions had remained for a long time, Donovan's solution was given with the effect of causing the eruption to disappear in a very short time, but he had never again had a similar case. He had had many cases in which the lesions disappeared spontaneously.

DR. FOX said that he had obtained the best results by touching each individual lesion with pure carbolic acid; latterly, however, he had been using the bichloride of mercury in ointment. He mentioned a case under his care in the hospital, in whom the surface from head to foot was covered with an eruption like an infiltrated or dry eczema, with here and there a few typical patches of lichen planus. In this case a very weak solution of carbolic acid caused a severe dermatitis of the hands and feet.

DR. SHERWELL suggested the use of a lotion containing thirty to forty grains of nitrate of silver to the ounce, with spiritus ætheris nitrosus, one part in four. He believed that it would allay the itching.

DR. ROBINSON said that he differed from Dr. Taylor in regard to the mode of the extension of the lesions. They frequently begin as small spots and become as large as peas, sinking in the centre. The centres will clear up to a certain extent, presenting a violaceous surface. He has watched individual patches getting larger by spreading peripherally. They may commence as small as a pin's point. He believed that the patch on the penis had become larger by peripheral increase and not by coalescence of a number of papules.

DR. TAYLOR conceded what Dr. Robinson said in reference to the peripheral extension of patches of lichen planus, and he found that the patches clear up in the centre, becoming violaceous; still the skin was not healthy as in psoriasis: in other words, where the clearing up process has taken place, there is a hyperæmic condition left.

DR. ROBINSON said there was another form of lichen planus, resembling a dermatitis or follicular eczema, but differing in the length of time that an individual lesion remains. He usually gave tonics, especially strychnia; this patient was taking iodide of potassium without much benefit, and he soon intended to give tonics.

DR. KEYES shewed a peculiar

#### CASE OF ACQUIRED SYPHILIS.

X., aged 19, was presented to the Society a year ago. At that time his history was that he had been perfectly well until the age of 7, when, as he says, he had rheumatism and fever. When 16 years old he went to Mt. Sinai Hospital with a swollen testicle, which had been gradually growing larger for several months. The malady was called orchitis, and treated by strapping with rubber; great pain resulted, and finally his testicle was removed with the knife. He remained well until August, 1884, when two lumps appeared on his face, one on the forehead first, then another on the left malar bone, they grew slowly without pain. He was first seen by Dr. Keyes in the autumn of 1884, who concluded that the swellings from their physical characters must be gummata, and treated him accordingly by mixed treatment, with rapidly increasing doses of the iodides. He was then presented to the Society. His treatment has cured the tumor on the malar bone, a depression marking the site of the absorption of bone, although there never was any breakage of skin, or escape of a piece of dead bone. The lump on the forehead was too far advanced to allow a cure by medicine. The gumma softened, and the ulcer disclosed bare bone. Dr. Keyes removed a flat scale of the outer table some weeks ago; a portion of the dead bone still remains in the bottom of the ulcer. The other testicle is now enlarged as was its fellow before removal. The patient is still increasing his dose of iodide, which he took badly at first; he has only reached a drachm and a half daily, but is doing well in all respects. His father and mother are strong and healthy. They were married twenty-one years ago, and have seven children; the patient, and six other healthy ones which were born after he was, all are living and free from disease. There is no specific history in the family or in the patient except as mentioned. His teeth are good, and he has no evidence about him of inherited disease, although there is a slight scar in the corner of the mouth. There is no evidence to

show that the patient acquired his malady personally, and the whole question of the origin of the disease is involved in obscurity.

Dr. Keyes presented the case as a curious one, because of the inability to ascertain how the poison entered the system. He believed that it was an accidentally acquired syphilis.

Dr. BRONSON did not consider it a case of inherited syphilis; he thought if it were, it would of necessity have affected the development of the body, the teeth would also be affected, as well as the shape of the head.

Dr. MORROW also thought that the clinical appearances suggested acquired rather than inherited syphilis. He asked Dr. Keyes if he expected to get the same results from specific treatment in a case of late hereditary syphilis, as in the acquired form. He thought that most late hereditary syphilitic lesions were rebellious to specific treatment, and that tonics were preferable.

Dr. KEYES, in reply, said that when a hereditary lesion made its appearance early and remained persistent, lasting even beyond puberty, it was difficult to treat. He did not think that a tardily developed hereditary syphilis was more difficult to treat than an acquired, provided that a number of healthy years intervened before the appearance of the lesions. He mentioned instances where patients were unable to take their medicine when in the city, but if sent to the country their systems were toned up, and they could take the mixed treatment with the greatest benefit, because the hygienic surroundings were better.



Dr. PIFFARD showed a

COMEDO EXTRACTOR.

It was made after the pattern designed by Unna, but differing from it in having a convex surface instead of a flat one at each end, and in having the apertures cut to gauge and the openings in convex surface slightly countersunk; the shank was also thicker.

## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

LEPROSY IN NORWAY—TREATMENT OF PSORIASIS BY CHRYSOPHANIC ACID AND BY THE VARIOUS MEDICATED PLASTERS—INQUIRIES INTO THE TOXIC PROPERTIES OF NAPHTHOL, AS BEARING UPON THE TREATMENT OF SCABIES BY THAT SUBSTANCE—INSTRUCTIONS RESPECTING CONTAGIOUS MALADIES OF THE HAIRY SCALP—TREATMENT OF SIMPLE CHANCRE OR CHANCROID—ON THE EXPRESSION OF JUICE, AS A MEANS OF DIAGNOSTIC DIFFERENTIATION BETWEEN SYPHILITIC CHANCRE AND HERPES.

**Leprosy.**—Professor H. Leloir has published in several journals (*Vide Semaine Médicale*, June 24, 1885) a summary of his observations upon leprosy in Norway, during a recent visit to that country. I will pass over his description of the three forms of the disease—the tubercular, the anesthetic, and the mixed—since the synthetic clinical pictures which it embodies would have to be quoted in their entirety, and they correspond, on the whole, to what the standard authors have already taught us. I wish to dwell on those passages only in which the question of



the contagiousness of leprosy is considered. In August, 1884, when the first reliable statistics were collected, the total number of lepers in Norway was about 1,500; nearly 900 of these must have been at large. Besides the 550 in the lazarettos, there were some 50 lepers in the general hospitals, on the same footing with the other patients, and able to leave whenever they wished. Isolation, therefore, in the case of the Norwegian victims, is far from being universally enforced, despite the institution of the lazarettos in 1856 and 1860, and yet their number has gone on diminishing at a remarkable rate since those dates. According to Dr. Kaurin, there were in Norway, in 1856, 2,827 lepers; in 1858, 2,802; in 1859, 2,823; in 1860, 2,785; in 1870, 2,538; in 1876, 2,035; in 1879, 1,774; in 1880, 1,656; lastly, in 1881, from 1,500 to 1,600. Hence, Dr. Leloir is led to propound the question, whether this happy result is really attributable to the establishment of lazarettos. He inclines to think that it is not, but that the leprous families die out after a few generations, owing to the direct effects of the disease, to celibacy, or to their isolation. To these causes, he thinks, may perhaps be added the emigration of Norwegian lepers to the United States. He believes that leprosy is only contagious in a very slight degree, if at all—indeed, it is easy to perceive, from the tone of his article, that he is almost convinced of its non-contagiousness. He refers to cases in which lepers have cohabited with their wives during a lengthened period without affecting them, and in which the said wives have even given birth to perfectly healthy children. He cites the experience of a certain physician who, after several unsuccessful attempts to inoculate himself with tuberculous leprosy, met with the same failure in his experiments upon twenty healthy individuals. I do not wish, on the present occasion, to discuss these opinions of my excellent friend Professor Leloir. You, in America, are in a much better position to do so, since the question of the contagiousness of leprosy is the order of the day in the United States. I will merely remark that the history of leprosy in the Sandwich Islands affords evidence in favor of its contagiousness whose force it will be difficult to overcome.

**Chrysophanic Acid in the Treatment of Psoriasis.**—Dr. Derobert, in a recent thesis, sets forth the advantages to be obtained from the use of chrysophanic acid in the treatment of psoriasis. The observations on which his essay is based were made in the service of Professor Fournier. In M. Besnier's service the psoriasis-patches are first painted with a ten-per-cent solution of chrysophanic acid in chloroform, which when dry is coated with another protective layer of gutta-percha dissolved in the same vehicle (10 white gutta-percha : 90 chloroform). Professor Fournier, on the other hand, employs but a single solution of gutta-percha and chrysophanic acid in chloroform, and this is only applied once. In this way the clothing is more liable to be soiled than by the former method, but it involves an economy of both time and money which is by no means to be despised in hospital practice. The coating is to be renewed when necessary. By this process most of the cases are cured within periods varying from ten days to a month; sometimes, though rarely, only four frictions are required. I should not have said so much on this subject, if the thesis in question had not contained an expression of opinion which seems to me to go a little too far. I refer to the statement that no danger need be apprehended from general frictions with chrysophanic acid, because this agent is devoid of toxic properties and is not absorbed by the skin. On the contrary, I am convinced that it ought to be employed with the utmost caution, and should never be rubbed in upon the general surface without a previous testing of the patient's susceptibility by partial applications. I well remember having seen, in the year 1880, a man dying at the St. Louis

Hospital, with the most intense general erythema, accompanied by symptoms of severe poisoning, in consequence of a too powerful application of chrysophanic acid. Quite recently I had an opportunity of observing, in the service of Dr. Vidal, a case of general exfoliative dermatitis of two months' duration, with intense fever, which had been brought on in the same way. Such facts as these, even though of rare occurrence, ought, it seems to me, to have made M. Derobert a little more careful.

**Ichthyol in the Treatment of Scabies.**—Several years have passed since Kaposi extolled the virtues of naphthol  $\beta$  as a remedy for various cutaneous affections, and particularly for scabies. This process is unquestionably advantageous when we do not wish to subject our patients to the treatment in vogue at the St. Louis Hospital, and which is known as *La Frotte*—a treatment whose efficacy is undeniable, since it effects a radical cure within an hour and a half, but which is painful, troublesome, and difficult of thorough application. Unhappily, Neisser, in 1881, proclaimed that naphthol  $\beta$  was far from being an inoffensive substance, that he had observed complaints of the kidneys in children as results of its employment, and that animals on whom he had experimented with subcutaneous injections of an oily solution of naphthol, had died with symptoms of hæmoglobinuria. These experiments have been repeated by MM. Josias and Nocard (*Vide Annales de Dermatologie et de Syphiligraphie*, May, 1885). They have shown that cobayes weighing 400 to 500 grammes can be killed by injecting subcutaneously 15 to 30 centigrammes of a 1-to-10 alcoholic solution of naphthol, and that an injection of one gramme of the same is fatal even to a rabbit weighing 2,500 grammes; but that in large-sized animals naphthol  $\beta$  is incapable of giving rise to any serious symptoms whatever; their conclusion is that naphthol  $\beta$ , in ordinary medicinal doses, is an excellent remedy against scabies, and entirely harmless.

**Contagious Diseases of the Scalp in Children.**—The senior physician to the St. Louis Hospital, Dr. Lailler, has published (*Vide Revue D'Hygiène et de Police Sanitaire*, July 20, 1885) a set of directions respecting contagious diseases of the scalp in children, designed for the use of parents, teachers, and the managers of public institutions. It cannot be too highly commended to the attentive perusal of physicians. The following are some of the precautions advised by the distinguished author: no child should be admitted into a school without a medical inspector's certificate that it is free from any contagious disorder. Boys' hair should be kept short; as also that of girls until the age of 7 or 8 years. It should be frequently inspected. The children's heads should be uncovered at all times, as far as possible, even during recreation in the open air. Their caps should be of a washable material. Boys' heads should be washed once a week in winter, oftener in summer; using for the purpose a decoction of Panama wood, followed by a rinsing with pure water, and a thorough drying with towels. These ablutions need not be so frequent in the case of girls, but greater care must be taken in drying their hair. In boarding-schools, each pupil should have his own brush and comb, which should be kept perfectly clean. Every child who has had ringworm, and has been re-admitted into school on a medical certificate, should remain under special surveillance, and be inspected by the doctor once a fortnight during the first quarter.

Speaking of ringworm, I must not forget to mention the recent thesis by Dr. Manuel Venegas y Canizaries—a good summary of the latest ideas concerning this topic, and of the methods at present employed at the St. Louis Hospital in the treatment of pelade, of favus, and of trichophytosis.



**Treatment of Chancroid.**—M. Maurice Notta has put forth an article in *L'Union Médicale*, July 18, 1885, treating of the different methods which have been employed for the treatment of simple or non-infecting, non-syphilitic chancre—the chancroid of English and American writers. He divides them into two kinds—one in which only a topical and superficial action is sought to be produced upon the chancroid; and another which aims at its complete destruction from the very base, and its transformation into a simple sore. To the first class belong the applications of aromatic wine, tartrates of iron and potash, glycerin, dilute tincture of iodine, decoctions of oak or of Peruvian bark, chlorine-water, resorcin, oxygenated water, tincture of thuja, guaco, perchloride of iron, sulphate of iron, silicate of potassium, chloral; also of absorbent powders, such as those composed of calomel, bismuth, camphor, oxide of zinc, quinine, or ratanhia. All these agents may produce good results, but they are less efficacious than those which constitute the second class. A soft chancre may be destroyed either by excision, which is scarcely ever an advisable procedure, or by cauterization, the means usually adopted. Formerly, the arsenical preparations, Ricord's sulpho-carbolated, Vienna paste, acids more or less diluted, etc., were made use of for this purpose. In France, at present, we employ a solution of nitrate of silver, 1 : 30, bichloride of zinc, in the form of *paté de Canquoin*, or a concentrated solution of iodoform—this last having been brought into favor by MM. Besnier and Lailier in 1867—salicylic acid combined either with wheat flour or with powdered gum (one part of salicylic acid to four parts of excipient); pyrogallic acid, 1 : 5 (Vidal); finally, the thermo-cautery. Quite recently, M. Aubert, at Lyons, has resorted, with success, to the administration of prolonged hot baths; and I have myself effected cures of phagedenic soft chancres by means of very hot cataplasms repeatedly applied. According to M. Aubert, a temperature of 38 C., if maintained long enough, will suffice to modify the chancrous poison, and transfer the virulent ulcer into a simple sore. M. Notta believes that the most efficacious method hitherto devised consists in the complete and simultaneous cauterization of all the patient's soft chancres by means of the thermo-cautery, followed by an antiseptic dressing. I refrain from further details on this subject, since the management of chancroid is so admirably treated in the last edition of Bumstead and Taylor.

**Diagnosis of Chancre and Herpes.**—In a recent communication to the *Journal des Connaissances Médicales*, Professor H. Leloir describes a means, which he calls the expressure of juice, for differentiating an infecting chancre from herpes. It consists as follows: when a syphilitic chancre is squeezed between the fingers, only a small quantity of fluid, if any at all, is brought to the surface, and it is very difficult to make it exude a second time. In herpes, on the other hand, the same process forces out a drop of transparent serum, resembling the discharge from certain eczemas, and this result may be produced several times in succession. The histological structure of the respective lesions will serve to explain this difference, a chancre being a syphiloma, a hard and incompressible neoplasm, while herpes, on the contrary, is characterized by the occurrence of local hyperæmic oedema, with vascular dilatation.

Paris, 1885.

DR. L. BROCCQ.

## Reviews.

---

ACNE: ITS ETIOLOGY, PATHOLOGY, AND TREATMENT. A PRACTICAL TREATISE BASED ON THE STUDY OF ONE THOUSAND FIVE HUNDRED CASES OF SEBACEOUS DISEASE. By L. DUNCAN BULKLEY, A.M., M.D., Attending Physician to the New York Skin and Cancer Hospital, Etc. New York and London: G. P. Putnam's Sons, New York.

Dr. Bulkley enjoys the distinction of being the most voluminous writer on diseases of the skin in this country, and we observe with pleasure that each succeeding production is an improvement upon its predecessor. From a careful examination of the work before us, we regard it as the most creditable contribution the author has made to the literature of dermatology.

Chapter I. is devoted to the anatomy and physiology of the sebaceous glands. The admirable delineations of Sappey which serve as the basis of description, are supplemented by observations of other distinguished authorities.

In Chapter II. the nosology of acne is considered at some length. The historical details relating to the nomenclature and classification of sebaceous diseases by different writers, while adding but little of practical value to the work, are yet quite appropriate in a monograph which aims at a complete and exhaustive presentation of the subject.

Acne is defined "as a functional or inflammatory disease of the sebaceous glands, exhibiting excessive and abnormal, or deficient secretion of sebum; or the inflammatory elements of congestion, papules, pustules or tubercles, located in and about the sebaceous glands; or any or all of these features combined." It will be seen that the author includes anomalies of secretion of the sebaceous structures as well as glandular and peri-glandular inflammations, thus giving a more comprehensive signification to the term acne than is recognized by modern authorities. From a clinical point of view, it is quite proper to class together functional and inflammatory sebaceous diseases, since both forms often coexist in the same individual. Of more doubtful propriety, however, is the inclusion of acne rosacea, which many modern writers entirely separate from the acne group, since the implication of the sebaceous glands is secondary to the erythema and other vascular changes; moreover, rosacea ordinarily occurs at a different period of life and under the influence of causes which have no etiological relation with the production of other forms of acne.

In discussing the etiology of acne, reference is made to the varied and conflicting opinions of different authorities upon this point. Especial prominence is assigned to the rôle played by the nervous system in the causation of acne. He says "the more the subject is studied in all its bearings, the more does it seem probable that, in the majority of instances, the direct cause of faulty secretion from, and congestive and inflammatory action in and about the sebaceous glands is found in a nerve influence transmitted or reflected from other organs or portions of the body."

Among other general or systemic causes, anæmia and debility, imperfect digestion, constipation, disturbances of circulation, etc., are referred to as standing in close etiological relation with disorders of the sebaceous glands. The in-

fluence of sexual derangements upon the development of acne is considered at some length, and the conclusion arrived at that while in the male subject this causal connection is comparatively rare, in the female it is much more positive and pronounced. A subordinate importance is assigned to the influence of local irritants as a direct exciting cause of acne, while allowing that they often aggravate an existing cause.

The clinical description of the various forms of acne is considered in Chapters V. and VI. with their diagnosis and treatment. Considerable space is devoted to the pathological anatomy of the several varieties. This part of the subject has been worked up with much care, and the text is enriched with a number of original drawings by Dr. George T. Elliot, representing the microscopical appearances. The treatment of acne, while containing nothing notably new or peculiar, has been brought fully up to the latest advances made in this department of dermatological therapeutics.

The book concludes with a chapter on diet and hygiene, and a complete and well selected formulary. We commend this work to both the specialist and the general practitioner as the most admirable exposition of the etiology, pathology, and treatment of acne that has ever been given to the profession.

---

## Selections.

---

### THE SIGNIFICANCE AND DIAGNOSIS OF GONORRHOEA IN THE FEMALE.

At a recent meeting of the Hamburg Medical Society, Dr. Lomer read a paper on gonorrhœa in the female, in which he calls attention to the very important rôle which the disease plays in gynecology.

Sänger has made the statement that one-ninth of all cases coming to the gynecologist for treatment are of gonorrhœal origin. Indeed, he is of the opinion that gonorrhœa with its consequent ills is altogether more dangerous and more pernicious than syphilis. To many this statement will appear an exaggeration, but it must not be forgotten that by spreading to the Fallopian tubes a gonorrhœa may set up a pyo-salpingitis which, by rupture, may cause a fatal peritonitis.

This outcome of a gonorrhœa is indeed rare, but grave diseases of the uterus and its appendages resulting from it are daily met with.

The fact that gonorrhœa so frequently passes unrecognized in women, the author believes to be due to a double cause; the patient herself is often unconscious of the disease; and no pathological process is apparent to point out the diagnosis to the physician. Only in recent cases are we sure of finding an inflammation of the vagina with swelling, injection, and granular thickening of the mucous membrane.

The process in the hidden cases is located in the cervix.

Bumm has pointed out the fact that, in searching for gonococci, the secretion from the cervix must be used, and that the cylinder epithelium of this region offers a better soil for the growth of the gonococci. The author has examined

two hundred women at the University Clinic for Women in Berlin, with the following results:

1. He concludes that the vaginal secretion is unsuitable for the discovery of gonococci.
2. That you must look for them in the secretion from the cervix.
3. That only such cases should be regarded as gonorrhœal as show diplococci shut within the pus cells.
4. That there are, nevertheless, certain doubts about positively assuming the existence of gonorrhœa based on the discovery of such diplococci, for the reason that their existence in slight cases of vaginitis in children, and the frequent appearance of colonies of diplococci in lying-in women, are facts that not yet sufficiently explained.—*Deutsche Med. Wochenschrift*, No. 43.

### PROFESSIONAL DERMATOSES.

By the above term Gibout designated, in a recent lecture at the St. Louis Hospital in Paris (*Gazette des Hôpitaux*), those diseases of the skin met with in persons engaged in certain occupations.

Among the employments commonly giving rise to skin affections may be mentioned that of the grocer, who handles such irritating substances as salt, pepper, acids, etc.; dish-washers, who have the hands and arms continually in fatty water, which is first very hot and then cold; blacksmiths and iron-workers, whose faces, arms, and chests are exposed to the intense heat of the furnace; painters, dyers, distillers, and mortar-mixers, all of whose hands come in contact with irritating substances.

Whether acute or chronic, professional affections have special characteristics by which they may be easily recognized:

1. Contrary to the nature of syphilitic and herpetic diseases, they have no tendency to generalize themselves; being produced by local causes, they are limited to the sphere of action of the cause, and remain local.
2. Differing from herpetic affections, they are not pruriginous.
3. Differing again from herpetic affections, they do not present a unity of lesion, that is to say, at the same point we find a reunion or running together of lesions of various kinds; thus we see plaques of eczema surrounded by papules of lichen and pustules of ecthyma, a mixture of affections of different kinds.
4. Differing from herpetic and syphilitic diseases, they have no duration, tenacity, nor tendency to recur. When the local influences which have produced them are removed, they at times get well of themselves without any treatment. Properly treated, they rarely last over eight days, and once cured, do not return unless the patient is exposed again to the same producing causes.
5. They do not affect the general health.
6. They are neither contagious nor incurable.

In treating these cases, the first thing to accomplish is the removal of the cause; this having been done, emollient dressings are recommended, such as poultices of potato, flour, and local baths of bran or starch-water, etc.

If the affection assume a chronic form, a stimulating treatment may be called for, such as frequent applications of oil of cade, tincture of iodine, or a solution of corrosive sublimate, followed by glycerole of starch, vaseline, or oil of sweet almonds, to render the skin again elastic and pliant. Once cured, the patient should give up his occupation, or resume it with great caution.



## LUPUS TREATED WITH COLD.

ALMOST all methods of treating lupus have for their aim the destruction of the diseased tissue.

Prof. Gerhardt, of Berlin, proposes a method which has proven somewhat successful in his hands, and which has for its object the destruction of the bacilli which of late years have so constantly been found in lupus tissue. While believing that the tubercle bacillus is a principal factor in the disease, Prof. Gerhardt argued, from the extremely slow progress of many cases of lupus, and from the fact that, at times, many specimens must be examined before the bacilli are found, that some other element must be present which prevents the bacillus from spreading and multiplying with the same rapidity noticeable in other parts. For example, in lymphatic glands the bacilli are often found in closely packed masses filling up the microscopic field, whereas in a giant cell of lupus scarcely ever more than one bacillus is found.

This the writer explains by the superficial situation of lupus and its constant exposure to a lower temperature, and in fact bases his treatment upon this theory of cold exercising a deterrent influence upon the bacilli, hindering their spread. The patient lies for three hours, twice each day, in such a position that an ice-bag suspended from a hook will cover as nearly as possible the lupus patch without making disagreeable pressure.

Four cases were treated, three for a short, and one for a longer period. The results were such as to render the method worthy of further trial.

The advantages claimed for the ice-bag treatment are that the disease is checked in an equally short, if not a shorter time, than by other methods; that the surrounding tissues are not injured, and that the activity of the tubercle bacilli is checked, if not wholly destroyed.—*Deutsche Medicinische Wochenschrift*, October 8, 1885.

## INTRA-MUSCULAR INJECTIONS OF METALLIC MERCURY IN SYPHILIS.

DR. LUTON, of Reims, makes the following propositions touching the question of introducing mercury into the system by the hypodermic method.

1. The muscular tissue absorbs metallic mercury more readily than does the cellular tissue.

2. This absorption is proven: *a*, by the therapeutic effects; *b*, by the possible, but not constant, production of mercurial stomatitis; *c*, by direct examination in experiments on animals.

3. Sulphur, employed as an electuary in doses amounting to at least seventy-five grains per day, is far superior to chlorate of potash as a remedy for stomatitis.

4. The dose of metallic mercury at the outset should be at the most fifteen grains, taking as a rule for a repetition of the dose the time when its equivalent in bichloride of mercury would have been taken. Thus one gram of mercury would give 1.354 gram of bichloride.

5. The advantages of this method are: *a*, efficiency; *b*, avoidance of digestive derangement; *c*, the possibility of separating the injections by intervals which can be calculated.

6. Intra-muscular injections of metallic mercury are only recommended, at the present time, for the severe and inveterate cases of syphilis which have



arrived at the period of transition or are in the tertiary stage.—*Gazette des Hôpitaux*, September 12, 1885.

### HAMAMELIS VIRGINICA IN THE TREATMENT OF PROSTATIC DISEASE, AND OF BUCCAL CANCER.

TWO cases that have recently come under my care seem to me interesting in connection with the use of hamamelis virginica.

One is a case of enlarged prostate requiring the use of the catheter, in which periodical hæmorrhages have occurred simultaneously from the urinary passages and the rectum, no doubt from a congested condition of the veins of both parts. In this case, washing out the bladder with a solution containing one drachm of tincture of hamamelis, and one-half drachm of carbolic acid, in about twenty-five ounces of warm water, has had an excellent effect in arresting the bleeding, and also in allaying the irritability of the parts. Since the use of the injection, the urine has been passed without the catheter; but that is probably due to relief of congestion by the bleeding. The other means found most useful have been leeches to the perinæum, and saline purgatives.

The other case is one of cancer beginning in a rare seat—the right tonsil, and subsequently involving the tongue. In the diagnosis of this case, I had the assistance of Dr. Hodgkinson, of Manchester. A short time ago, a smart hæmorrhage occurred, and tincture of hamamelis in ordinary medicinal doses was prescribed. The bleeding was arrested; but the medicine was found to have such an excellent effect in preventing the formation of sticky secretion on the ulcerated surface and in adding to the comfort of the patient, that it was adopted as a permanent mode of treatment.

The above are comparatively simple cases, and the effects of treatment can only be palliative; but it seems to me that an account of them, as a contribution to the knowledge of the therapeutics of a new drug, may be of some use.—MACKENZIE, *Brit. Med. Jour.*, Oct. 31, 1885.

### UNIQUE MODE OF CONTAGION OF GONORRHOEA.

M. HORAUD communicates the following unique case to the *Société Médicale de Lyon*.

M. C., student of medicine, had four years previously an attack of gonorrhœa which lasted about twelve days, and disappeared leaving no trace. This was the only venereal disease he had ever had. On the 10th of July, he visited a public house of prostitution, and with the view of escaping all risk of contagion, he had a connection *ab ore*, with a woman accustomed to this form of exercise. He immediately washed himself and dried the penis with a clean towel. He states that he had no other contact with the woman. The next day he felt a sensation of warmth in the urethra, and pressed out a whitish drop.

On the 13th of July, Dr. H. examined him and found an abundant purulent discharge, the examination of which demonstrated the existence of globules of pus and numerous gonococci. He was treated with injections, and the discharge disappeared in the course of fifteen days.

The woman was examined and found to have neither buccal inflammation nor urethro-vaginitis. How explain the development of gonorrhœa in this case? It could not be a simple inflammation produced by suction, since the discharge contained the gonococcus, which proves that it was a gonorrhœa determined by contagion. The probable explanation is that the urethra of my patient encountered

in the mouth of the woman, gonococci deposited in a recent intercourse *ab ore*.—*Lyon Médical*, Nov. 1, 1885.

### HERPES FOLLOWING THE EXTERNAL USE OF BELLADONNA AND ATROPINE.

DR. MACKINTOSH reports, in the *British Medical Journal*, Oct. 17, 1885, a case of a patient suffering from chronic rheumatism, who was ordered belladonna liniment for application to a painful knee-joint. The use of this was followed by an eruption of herpes, with a good deal of swelling over the seat of application of the liniment. Recently he had an attack of iritis in right eye, for which a solution of atropine was used to dilate the pupil. Some of the solution ran over the cheek and was, in a few hours, followed by an herpetic eruption of exactly the same character as had followed the use of the belladonna liniment. The swelling was so great that the eye was completely closed.

## Items.

**LOTIONS OF SULPHIDE OF POTASSIUM.**—Sulphide of potassium is a valuable remedy in various skin affections, but hitherto it could not be conveniently used on account of its disagreeable odor of putrid eggs. A method of dissolving it, and, at the same time rendering it agreeable, is to add a quantity of tincture of benzoin equal to the amount of sulphide employed. Thus a solution composed of 15 grains of sulphide of potassium, 15 minims of tincture of benzoin, and 3 ounces of water, emits a perfume much resembling the flower Acacia.—*Exch.*

**FOR BALDNESS.**—Bartholow advises :

Ext. pilocarp. fl. ....	.....	℥ i.
Tinct. cantharid. ....	.....	℥ ss.
Lin. saponis. ....	.....	℥ iiss.

M. Sig. Rub into scalp thoroughly daily.

**NEW EXCIPIENT FOR MERCURIAL OINTMENT.**—Dr. Yvon propose to substitute soft soap for lard. The soft soap mixes more thoroughly with mercury, and is soluble in water. Mercurial ointment prepared with soft soap can be kept for an indefinite time, neither does it melt when exposed to heat. It does not irritate the skin, and is easily removed by soap and water.

**HYPERIDROSIS.**—Agaricine, in doses of one-sixth of a grain, to be repeated, if necessary, is an efficient remedy for excessive perspiration, and there appear to be no disagreeable or undesirable effects attendant upon its use.

**INFANTILE ECZEMA.**—In the *Rev. Thérap.*, October 1, the following preparation is recommended for the cure of infantile eczema :

R Vaselinei .....	.....	℥ i.
Picis liquidæ,		
Hydrarg. chlor. mit. ....	.....	āā 3 ss.

M.

Apply two or three times daily until cure is effected, unless the remedy becomes too irritating, when its use should be suspended for a short time.

# JOURNAL

OF

## CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

FEBRUARY, 1886.

No. 2.

---

### Original Communications.

DOUBLE COMEDO, DUE TO A HITHERTO UNDESCRIBED ANOMALY  
OF THE SEBACEOUS DUCTS.

BY

A. H. OHMANN-DUMESNIL, A.M., M.D.,

Professor of Dermatology and of Syphilology in the St. Louis College of Physicians and Surgeons

A REFERENCE to dermatological literature will reveal the fact that all authors are agreed in their description of comedo, in that it consists of a greater or less inspissation of sebum in a sebaceous follicle, and that by exercising moderate pressure about the periphery of the duct, a small plug of sebum is forced out, the outward extremity of which is colored black by some cause or other. And we learn, furthermore, from the observations of anatomists and of dermatologists that each sebaceous gland has but one duct, and that each duct is provided with but one orifice. At least, that is what a careful reading would lead one to infer. The condition I am about to describe is one so altogether different and apparently unique, although met with in two cases, that I have taken the greatest pains to assure myself of its existence, and have also been fortified by the independent observations of others upon the same cases. I am indebted to Dr. A. C. Bernays, of St. Louis, for the opportunity of seeing these cases, he having kindly referred them to me. Their histories, in brief, are as follows:

CASE I.—Mr. H. F——, aged 33, unmarried, is of Jewish extraction, and a marked brunette. His business is that of a commercial traveller. When about 23 years of age, he acquired syphilis of a mild type, and was subjected to no treatment at the time. He had always been healthy, and continued to be so until about 1879, when he consulted Dr. A. C.

Bernays about an eruption upon his back. The doctor, in his examination, noted mucous patches in the mouth at that time. He placed him upon proto-iodide of mercury, and continued it for about six months. The symptoms, however, kept growing worse. Some time after, he returned with excavated ulcers of the upper lip. These were treated locally with the cautery, and he was ordered a course of mercurial inunctions which resulted in an apparent cure, lasting for a few years. For the last two years, he has had mucous patches, syphilitic infiltration of the tongue, and various other manifestations of the disease. When I saw him, his back was the seat of an acne, the lesions were papular, pustular, and tubercular, and, in addition, a considerable number of comedones existed. As to the distribution, appearance, and peculiarities of these last, I will speak more in detail further on.

CASE II.—Mr. A. S— is 32 years old, unmarried, and also of Jewish extraction. He is a very strong, muscular man, of a decidedly dark complexion. He acquired syphilis about seven years ago, but in a very mild form. Dr. A. C. Bernays, who treated him for that trouble, states that he did not observe any other secondary symptom but alopecia and mild squamous papules. He has remained apparently healthy since that time, being kept upon active mercurial treatment. His back is also covered with the eruption of acne in a papular and pustular form, together with tubercles here and there. Interspersed are numerous comedones having the same peculiarities as those in Case I., and which will now be described.

The comedones, in both cases, are well-marked, the skin not being elevated at the sites where they exist. The black points are very distinct, and they occur between the lesions of acne. The distribution of these comedones is all over the back, though inclined to be discrete. One peculiarity of the distribution is that many of them are apparently in pairs, the distance between such varying from one-eighth or less to about three-sixteenths of an inch. If the skin intervening between the two points be carefully examined, it feels as if there was something beneath it of a cylindrical shape, of a diameter a little in excess of that of an ordinary pin, and apparently lying horizontally. By bringing somewhat firm lateral pressure upon one of the comedones in the direction of the other, it will be seen that the latter projects somewhat, and, by continuing the pressure, both follicles are emptied, and a "double" comedo is the result; that is, we find that there is but one plug, and that it is black at both extremities, as shown in Fig. 1.

Taking a fine probe (a piece of silver wire or a blunt pin) and introducing it at one opening, it is found that it will appear at the other opening, and project out of it, as shown in Fig. 2.

Here and there are to be found, scattered over the back, long black



hairs, each one occupying a solitary position. The development of the glandular system is somewhat above the average, and the acne, which is present, has been very rebellious to all forms of treatment.

These cases present many interesting points for our consideration. It is a question, in the first place, as to what effect the syphilis has had in the production of the acne or in the prevention of its cure. That the eruption on the back is not syphilitic, all who have had an opportunity of seeing the cases are convinced of. The appearance of the lesions and their chronicity, together with other characteristics of acne which are

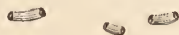


FIG. 1.

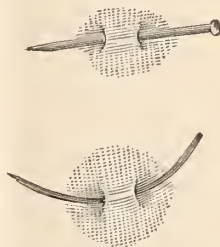


FIG. 2.

present, preclude any mistaken diagnosis. The presence of comedones, moreover, is confirmatory proof. What rôle the syphilis could have played in the anomalous condition of the sebaceous follicles is a question difficult to determine. The fact of its existence, of course, does not necessarily make it causative; but the very fact of its having been present leaves room for doubt.

The most interesting point, of course, is the double comedo and its plug. This latter is composed of one piece, cylindrical in shape and each extremity black. Moreover, vertical pressure over one opening will only result in pressing out a portion of the plug torn off, as it were, from its other half. Lateral pressure continued in the same direction has always been successful in forcing out the double comedo entire and apparently intact. This fact naturally brings up another question, and a most important one, connected with the sebaceous gland and its duct. Have we here to deal with a congenital anomaly or with an acquired defect? Are there two outlets to the same gland or has the duct separated just before reaching the surface of the skin? A third possible condition would be the uniting of the ducts of two glands at some point beneath the surface. It is impossible to answer, definitely, these questions at the present time. The question of a pathological or of a congenital origin might be resolved by the same means which we would adopt to determine the exact condition of the parts, that is, by microscopical examination. As neither one of the gentlemen has yet consented to permit the excision of a sufficient amount of skin to determine these points, they cannot be dwelt upon

here. It is to hoped, however, that one or the other will accede to the request and thus furnish a satisfactory solution to these interesting questions.

That the two openings connect with each other does not admit of a doubt for a moment. The fact that the plug which is forced out is unbroken is evidence of this. And the further fact that a fine blunt probe can be easily passed into one opening and out at the other, without using any force or disturbing the tissues in the least, except the slight elevation of the bridge of tissue connecting the two openings, is a very strong and indisputable argument establishing, in the clearest manner, the condition which has been described. This condition is, in my experience, a very rare one. I have repeatedly examined a number of cases of comedo to find a similar state of affairs, but unsuccessfully. Those whose attention I have called to this have also failed to find it; and nowhere in literature can I find the record of a similar condition.

A few interesting coincidences exist in both cases. The patients are of about the same age, have dark complexions, are of Jewish extraction, have had syphilis of a mild type, and have only the back implicated by acne. They have about the same form of the disease, and it is equally intractable in both. The glandular system of the skin is well developed in both, and they are well-developed men. Not the least curious is that two such cases should be seen at about the same time.

In conclusion I wish to state that Drs. A. C. Bernays, Geo. Bernays, W. F. Thornton, Chas. Barek, and others have seen and examined these cases, in my presence and out of it, and that they corroborate my observations, so that the personal equation of probable error due to defective eyesight, improper manipulation, or unconscious deception, did any of these exist, cannot be taken into consideration.

---

#### A CASE OF "RUPIA SYPHILITICA," CONFINED ALMOST EXCLUSIVELY TO ONE SIDE OF THE BODY.

BY

J. P. KNOCHE, M.D.,  
Kansas City, Mo.

**A**UGUST 5, 1885, I was requested by Drs. Lester to attend Mrs. C., who had been suffering from a skin trouble for some months. The patient was 44 years old, of medium frame, much emaciated, sallow complexion, nervous, and somewhat inclined to be hysterical. Upon an examination, I found an ulcerative eruption confined to the

right side of the body and a space of about one-half inch in diameter, on the left side of the face. (The character of the ulceration will be given, with the history elicited from the patient and her husband several days later.)

The patient's family history was good. She had several of the diseases incident to childhood. At the age of 17 she was quite strong and fairly well developed, at which time she was married to her present husband. Her first child, a male, was born in 1860. The mother says that he was always healthy until his 11th year, when he died of typhoid fever. The second child, born two years later, died from whooping-cough, age 11 months. The third child, born in 1868, was well nourished, strong, and hearty, and always enjoyed good health until 1873, when it died of small-pox. In 1873, she again conceived, but between the second and third months produced abortion with the aid of instruments; the same procedure was resorted to in 1875 and 1877. She stated that she suffered but little from the first and second abortions. The third confined her to her bed for some weeks. After her last illness, in 1877, she recuperated rapidly and remained in fairly good health until some time in July or August, 1882, when she became subject to dizziness and fainting spells, the latter coming on suddenly, lasting a moment or more, then passing off equally as rapidly.

In October, 1882, the *left* eye became inflamed, the pain being continuous and of a throbbing, lancinating character, and most violent between the hours of 9 P.M. and midnight. The doctor, she states, informed her that an ulcer was passing over the eye, and that it began at the outer side of the pupil and extended inward toward the inner canthus. The condition of the eye did not improve until four months had elapsed; after that time it continued to improve until July, 1883, when she was able to attend to her household duties. December, 1883, the same eye became again inflamed, the attack coming on suddenly; it grew worse until the middle of March, 1884, when vision had completely disappeared. April, 1884, the eye improved and continued so until September, 1884, when she could read large print with the same. The symptoms during this attack were the same as in the previous one. November, 1884, she became subject to rheumatic pain in the joints, pain over the tibia, and painful contraction of the muscles of the calf of the limb. This condition continued until December, 1884, when the first indication of skin trouble in the form of a pimple appeared midway between the ankle and knee-joints. It was accompanied by intense burning pain and severe itching. Soon a pustule formed in the centre of the pimple and dried into a crust. A few days later, the crust was removed, when an ulcer was found beneath. The ulcer extended peripherically until it acquired the dimensions of a silver quarter of a dollar, when it began to heal in the

centre. August, 1885, it was  $2\frac{1}{3}$  by  $1\frac{1}{2}$  inches; the edges were irregular, gyrated, and covered with thick dark crusts, which, when removed, exposed a deep ulcerated surface with a grayish base and very painful to the touch. December 16, a pimple formed anterior and inferior to the external condyle of the tibia, the symptoms and course of development being precisely as in the former, excepting its contour was semicircular. December 18, a small group of water-blisters, resembling in form a strawberry and accompanied by burning pain and severe itching, appeared on the surface over the base of the metacarpal bone of the thumb. The vesicles were lacerated by scratching, the part then became ulcerous, and followed the same course as the above. The ulcer, when seen, was oblong, 1 by  $\frac{3}{4}$  inch, and irregular edges. She attributed the water-blisters to a blow, stating that soon after the occurrence of the accident a red spot made its appearance, which became purple and was followed by the vesicles; the part did not become ulcerous until four weeks following the injury.

December 27, a pimple appeared on the outer side and middle of the ulna, and another on the inner side over the condyle of the humerus. The symptoms and development were as in the former; they acquired the size of  $2\frac{1}{4}$  by  $1\frac{1}{3}$  and 2 by  $1\frac{2}{3}$  inches; the former somewhat kidney shaped, the latter irregular and semicircular. January, 1885, a few pimples developed over the upper third of the humerus and scapula, and several on the thigh. Of the former, one became quite large and distinctly kidney-shaped. In February, a number of papules appeared on the scalp, right side, and limited to the space between the supra-orbital bone, parietal and lambdoidal sutures, also a few papules on the right side of the face and on the ear. Several days before, the spoken of papular eruption on the right side of the face and scalp made its appearance. A small group of papules developed on the *left* side of the face, and involving a space of about an inch square between the angle of the mouth and the nose. None of the symptoms experienced in the former attack were experienced in this case, such as burning and itching; the development progressed as in the former. In May, the last papule appeared, located on the small toe of the right foot; itching absent, burning severe. Mrs. C. suffered intensely from the spasmodic contraction of the muscles of the right foot and leg from the knee down, and forearm and hand; the attacks coming on suddenly, and especially before midnight, without any apparent cause, and lasting from fifteen to thirty minutes. During these attacks, the above-mentioned parts became rigid, with severe pain in the back part of the head and neck, and, as she states, the ulcers felt as if a hot iron was being pressed into them. The thigh and arms were not affected in the above manner. There was enlargement of the right epitrochlear glands, not the left, and the glands of the neck both sides.



Mr. C., the husband, always enjoyed good health until seven years after his marriage, 1866, he contracted from an impure intercourse a venereal disease, which manifested itself, about eight days following the coitus, as three small ulcers on the prepuce; they were soft and painful, much inflamed, discharge slight. The inguinal glands were slightly enlarged, and somewhat painful. The treatment consisted of "black wash" locally, and potas. iodide with mercury internally. The ulcers were cured in three weeks, and the treatment was stopped. In 1872 had a group of vesicles form on prepuce, with symptoms of burning and itching (herpes preputialis), which were cured in ten days with application of sulphate of copper, and the same year he also contracted gonorrhœa, followed by stricture and fistula, both cured after months of treatment. In 1873, had a papular eruption on the backs of the hands, which later became pustular and ulcerative; it remained in the latter state for seven months. During the last four weeks of this time, large doses of the mixed treatment were taken, to which the disease yielded. No local applications were used. The result of the eruption is still visible as white atrophic spots and cicatrices from the size of a hempseed to a split pea or larger. In 1880, he suffered from ulcerative sore throat, in 1883 had severe rheumatic-like pain confined to the tibiæ of both limbs, most severe during the night. The pain was relieved by taking 30 gr. iodide of potash three times a day. August 5, 1885, had psoriasis palmaris of both hands, and mucous patches at each angle of the mouth, and a node on the tibia of the right limb. He was placed on an anti-syphilitic treatment nine weeks since. The psoriasis of the hands and mouth, and the papules have yielded to the treatment. The mucous patches were also treated with spray of iodoform. Mrs. C.'s case was diagnosed as rupia syphilitica. She was given mixed treatment, and the ulcers were dressed with emplastrum hydrarg. The disease yielded rapidly to the treatment, and within three weeks after treatment had begun, the greater number of the old ulcers had healed, and in five weeks they had all cicatrized completely. Five days after taking treatment, the muscular contraction and pain had ceased.

---

**MICROCOCCUS OF VAGINITIS IN CHILDREN.**—In the vaginal secretions of 26 children, from three to ten years of age, treated in the Pesth Children's Hospital for various chronic diseases, Dr. Cseri found a coccus identical with Neisser's gonococcus and with that found in vaginal gonorrhœa. Many cases of chronic catarrhal vulvo-vaginitis are infectious. The spreading of this disease in children's hospitals takes place by means of washing, bath-tubs, closets dressing, and the nurses themselves.

## RECENT PROGRESS IN THE TREATMENT OF CHANCROID.

BY

CHAS. W. ALLEN, M.D.,

Surgeon to Charity Hospital.

THE multitude of remedies constantly suggested, advised, or urged in the treatment of chancre is an indication of the degree to which this form of venereal sore can be at times rebellious. The most obstinate form of the chancre is that designated as phagedenic.

Recently Spillman, of Nancy, has treated several cases of this variety by first scraping thoroughly with the sharp spoon or curette, excising the undermined edges with scissors, cauterizing with the thermo-cautery, and dressing with diluted liquor of Van Swieten. Among the cases so treated was one of a medical student who had inoculated himself with the pus of a soft chancre on the anterior surface of the thigh. The thigh, lower part of the abdomen, and the scrotum became involved in an extensive phagedenic sore.

Various forms of treatment, from the use of iodoform to prolonged hot baths, were tried, with no effect.

The treatment by scraping, etc., was rapidly followed by a cure in this as in the other cases.

## TO ABORT SOFT CHANCRES.

Hebra advises as follows:

Thoroughly cleanse the sore, treat with a preparation of potash-soap and spirits, dry carefully, apply pure salicylic acid, and cover with a plaster.

This treatment succeeds best when the application is renewed on two succeeding days, and the sore suppurates freely. After three days, a white scab covers the sore.

An emollient ointment is now to be spread on lint, and applied. Under this, the scab speedily separates, and the wound heals without any bubo formation.

## TREATMENT BY IODOFORM.

Iodoform is one of the most valuable applications in the slowly destructive forms of chancre. Its use, however, in private practice is almost impossible, unless in some way the odor be destroyed or disguised.

Men object to it from reason of its *give-away* perfume, and public women will not submit to its application as it keeps the men away from the house.

Only in the *virtuous*, therefore, can it be used pure without opposi-

tion. Iodoform has now so wide a range of application outside of venereal diseases that it is to be hoped these prejudices will soon disappear.

#### INODOROUS IODOFORM.

To render iodoform inodorous, several methods are recommended. Thus, at different times, tincture of musk, one drop to each forty grains, or oil of thyme, with the addition of a little thymol.

Dr. Schenk claimed, in the *Pharm. Zeitung*, 1882, that if one hundred and fifty grains of iodoform were rubbed up with one grain of carbolic acid and two drops of oil of peppermint, the odor would be so masked that it would not appear again even on heating.

Dr. Catillon has recommended the addition of tonka bean fragments to the iodoform bottle. This imparts an odor of bitter almonds, which, however, is lost after a few days' exposure to the air.

Dr. Andrews, of Staten Island, N. Y., says that cumarin, a derivative of the tonka bean, will completely cover the odor if added in the proportion of three grains to the drachm.

Balsam of Peru masks the odor in a measure.

Dr. Oppler claims that forty or fifty per cent of well triturated, freshly-roasted coffee will absolutely deodorize it.

According to the *Lancet*, Dr. Gillette has recently found that one part of sulphate of quinine and three parts of charcoal to one hundred parts of iodoform effectually accomplishes this result.

Dr. Krieger (*N. Y. Med. Record*, January 2, 1886) makes use of the ethereal oil of sassafras, a few drops of which, he says, suffice to remove entirely the offensive odor, and substitute therefor an agreeable aroma. I have made trial of this method of disguising the odor, and so far as my observations have gone, it does so entirely. I have succeeded with the non-ethereal oil (two drops to the drachm) in completely substituting the odor of sassafras for that of iodoform.

Prof. Morrow, in his recent work ("Venereal Memoranda," New York, 1885), after referring to the various expedients which have been employed for masking the odor of the drug, says (page 286), "I have found that oil of erigeron effectually disguises the odor for a time."

None of the odorless iodoforms have appeared to me to fully warrant their being so designated. Delicate olfactories will detect the peculiar odor sooner or later, in spite of any combination with which I am familiar.

I have recently tried the admixture of charcoal and quinine, and fail to find that it covers the odor to any marked degree.

Again, none of these combinations can equal in efficacy the pure iodoform, and it may be possible that some substances which destroy the smell may at the same time take away its principal virtue, as is the case with colorless tincture of iodine, and it is quite probable that the bad

results and ill-effects which have at times followed the use of iodoform have been due to its use in improper combinations. The solutions of iodoform in collodion appear to act well for a time, but as the ether evaporates the iodoform deposits in the bottle, the solution becomes darker in color, and loses to a great extent its characteristic odor, and does not produce the same effects as when fresh. A coat of the iodoform collodion whilst fresh has almost as strong an odor as the powdered drug.

The application of the collodion dressing is attended with some pain, and in the case of a large ulcer I have known it to be almost unbearable. To obviate this, the sore or ulcer may be covered with pure powdered iodoform; a thin layer of absorbent cotton is now applied over the sore, and over this is painted several layers of the iodoform in collodion. This forms a comfortable and efficacious dressing. If now it is desired to cover the odor of the iodoform, several layers of plain flexile collodion is painted over the whole. This will be found to give better satisfaction to the patient, and better results than any application of so-called odorless iodoform.

I have had such a dressing stay on a large syphilitic ulcer of the leg twenty-two days in a patient who was forced to make a journey in which he could not well dress the ulcer daily. On his return, I found that the ulcer was less than one-half the size when he started, the discharge being taken up by the absorbent cotton, which in this case I applied in a thick layer.

He was taking constitutional treatment at the same time.

#### ADULTERATION OF IODOFORM.

Attention was recently called, by the *Journal de Pharmacie et de Chimie*, to the adulteration of iodoform by picric acid, which is a cheaper drug, while possessing many properties in common with iodoform. Besides being a poison, it is capable of exploding when triturated in a mortar. Its detection is easy. When suspected iodoform is shaken up in cold water, it imparts to the water a yellow color. The addition of a little cyanide of potash to the filtered liquid produces no effect if the iodoform be pure. If picric acid be present, on the other hand, after ten minutes a brownish-red color appears, due to the formation of isopurpuric acid, and after a still further delay, a brownish-red precipitate of isopurpurate of potash takes place.

#### PYROGALLIC ACID.

I have recently called attention to the beneficial action of pyrogallie acid in the treatment of chancroids. This was first recommended by Vidal, of Paris, whose good results led others, among whom were Teril-



lon and Mauriac, to make extended trial of the drug. Vidal recommended a powder composed of one part of the acid and four of starch. I have used and recommended the application of the pure powder to be first applied and covered over with a layer of traumaticine, or a solution of pyrogallic acid in collodion.

#### CAUSTICS.

Of all caustics, the hot iron or thermo-cautery is probably the best for the majority of cases. With it we produce just the amount of cauterization we desire.

It can be used where other caustics would be dangerous, as in the vagina.

The pain produced, though severe, is of much shorter duration than that from chloride of zinc or nitrate of silver.

Since the introduction of cocaine into venereal surgery, the Paquelin cautery has lost its terror for the patient. Bono (*Gaz. delle Cliniche*, ii., 1885) says: "In cauterization, cocaine showed every desirable analgesic property of a sufficiently long duration."

Latouche (*Rev. de Clinique Méd.-Chirurg.*, January, 1885) strongly favors the thermo-cautery at a dull red heat, especially for chancroids of the vagina and neck of the uterus. He gives a number of cases in which the cure was complete in from eight to thirty-three days.

#### HOT BATH.

Dr. Aubert, of Lyons, has recommended prolonged hot baths as a means of treating chancroid.

Martineau and Lormand have carried out some experiments at the Lourcine Hospital in Paris, on the effect of baths at about 104° F. on chancroids and buboes.

They found that in all the cases the virulence quickly disappeared, and that auto-inoculation gave negative results after one or more baths in all cases excepting one, where the chancroid was within the urethra.

They approve of the treatment for severe cases, finding it quite practical, and that it hastens the cure in all cases.

Wet compresses should be put upon patient's head while in the bath, and an attendant be present for fear of syncope. It is not necessary to submerge the whole body.

#### SPONGE GRAFTING.

Dr. Pokrovsky applies fine slices of the best Turkish sponge, washed in a three-per-cent solution of carbolic acid, to chancroids and chancroidal buboes, and finds that this treatment brings about rapid cleansing and healing in about ten days. In syphilitic cases, the sponge dressing gives

rise to rapid cicatrization only after the syphilitic virus has been mitigated by specific treatment; otherwise the application of sponge causes disintegration of the tissues.

---

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

159TH REGULAR MEETING, DECEMBER 15, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. ALLEN presented two cases of

#### PSORIASIS TREATED WITH PYROGALLIC ACID.

F. A., 41 years old, for the past nine years has had psoriasis. On Nov. 17 last, when first seen at the Hospital by Dr. Allen, the whole body, as well as the palmar and dorsal surfaces of both hands, were covered with a typical psoriasis. Pyrogalllic acid in collodion was applied to the surface, and in about a week after, he was suddenly seized with pain in the heart of a "grasping" character, together with great dyspnoea. This disappeared under the use of digitalis and whiskey. Two weeks later he complained of colicky pains in the stomach, preceded by a chill, and accompanied by nausea and vomiting and great prostration: these symptoms also disappeared under appropriate treatment. At present the eruption has almost entirely disappeared from that portion of the surface to which the pyrogalllic acid was applied, and the skin is pliable and soft.

The second case, M. K., 60 years old, has had psoriasis for over thirty years. He was first seen by Dr. Allen last month, who gave him Asiatic pills, as many as ten each day, without any apparent benefit. About ten days ago, pyrogallol in collodion was applied to a portion of the body, and since then the eruption has cleared up faster there than elsewhere.

Discussion of Dr. Allen's paper

#### ON SOME OF THE USES OF PYROGALLIC ACID IN DERMATOLOGY AND THE DANGERS ATTENDING ITS APPLICATION.<sup>1</sup>

DR. SHERWELL said that he had relatively little experience in the use of pyrogalllic acid. He had been very cautious in applying it, and in his hands it had not produced such satisfactory results as other drugs, chrysarobin for example. He would like to ask the reader of the paper, when he speaks of mixing castor-oil with collodion, if he uses the flexile or contractile collodion. (Dr. Allen replied that he used the contractile.) He, Dr. S., suggested the use of pyrogalllic acid in mild forms of moist eczema, dusting the surface with the powder.

DR. JACKSON has used pyrogalllic acid in some cases of epithelioma and of lupus, and with satisfactory results. Some of the cases had been treated with the curette and by boring out with nitrate of silver stick without curing them. Under the pyrogalllic acid in ointment, followed by mercurial plaster, they healed. He has noticed that, in the strength of ten per cent in ointment, the acid did not

<sup>1</sup> Published in January number.

attack the hard edge of the ulcer, and he had to use there the nitrate of silver. He regards pyrogallic acid as a useful means of treating these affections where, for any reason, they cannot be operated on. He has also used the drug in psoriasis, and in chronic thickened patches of eczema, but it did not act so promptly as chrysarobin. Fearing its toxic effect, he has never used it in extensive cases of psoriasis.

DR. FOX had used pyrogallic acid constantly for several years. It was valuable in certain carefully selected cases, but it did not act as well as he would wish. He had used it in superficial epitheliomata and small patches of lupus. He first curretted with the object of removing most of the disease, and then used a ten or twenty per cent ointment of pyrogallic acid, afterward applying mercurial plaster. Deep epitheliomata of long standing and with infiltrated and cartilaginous edges could not be destroyed with pyrogallic acid, even where used for a long time. He found that in such cases an arsenical paste was infinitely superior. In the treatment of psoriasis, pyrogallic acid is not as good as chrysarobin, but where it is desirable not to stain the skin, or when the psoriasis is superficial, he uses ten to fifteen per cent of pyrogallic acid, three to five per cent of salicylic acid in solution either with the tincture or compound tincture of benzoin, which he had found preferable to collodion, as it is more pliable after drying. In mild cases of psoriasis, he has covered half the body with this solution without producing any bad effects, except a slight dermatitis. He has seen unpleasant local results follow the application of a twenty-per-cent ointment of pyrogallic acid to a raw surface. He has also used the acid in chromophytosis and other skin affections. In conclusion he would say that there are many cases of both epithelioma and psoriasis in which he would not depend upon its action for a cure.

DR. LEWIS said that he had used pyrogallic acid in some cases of epithelioma. In one case in particular he curretted and then applied pyrogallic acid ointment for a long time, finally using it in powder in full strength without much benefit. He came to the conclusion that it would not affect the indurated border of an epithelioma and also that it was too slow in its action. He considered it important in epithelioma that the action of the drug should be quick, and the healing take place as rapidly as possible.

DR. MORROW had considerable experience with pyrogallic acid in the treatment of psoriasis, and it was not unlike that of Dr. Fox. He spoke of several cases of psoriasis that he had treated in Charity Hospital, in which he applied pyrogallic acid collodion to one-half the body and painted the other with chrysarobin in traumaticine. He found that the action of the chrysarobin was more prompt and pronounced than that of the pyrogallic acid. Where there exists a peculiar susceptibility to the irritant action of chrysarobin, as is often found, pyrogallic acid may be substituted with advantage, although it is undoubtedly less effective. In epithelioma and lupus he uses a ten to twenty per cent ointment, or the powder, either mixed with some inert substance, or in its pure state. He differed with the members who asserted that the hard and everted edges of epithelioma were not affected by pyrogallic acid when used in its full strength. He, however, did not get such brilliant results as would lead him to use it in preference to other caustics. In regard to the dangers attending its use, he thought that they were slight indeed; he had never seen constitutional symptoms follow its absorption; in some cases there might be a mild erythema or slight dermatitis. He considered it to be much less irritating than chrysarobin.

DR. TAYLOR had employed pyrogallic acid in collodion for a long time in psoriasis, and in some cases of infiltrated and scaly eczema, but did not consider it as good as chrysarobin. He had also used one part of pyrogallic acid to three of bismuth in soft chancres and gummatous ulcers.

DR. ALLEN, in closing the discussion, said that he had never applied pyrogallol in moist eczemas, but had used it in the scaly forms which resembled psoriasis. In almost all cases of epithelioma and lupus, it was best to have the surfaces denuded before applying the pyrogallic acid. He thought that the chances of producing a dermatitis were less than when chrysarobin was used, and the drug could be employed for a longer time. He has had very much the same experience that the other members have had in producing an effect on the hard and everted borders of an epithelioma, although in one case pyrogallic acid appeared to reduce the hardening to a slight extent. The pyrogallic acid was chiefly applicable to those cases where there was excessive cell proliferation and where there was

a low vitality, or where chrysarobin is apt to produce a dermatitis, or does not act well in other respects.

He then gave the history of a case of supposed lupus of the nose occurring in a colored woman, 26 years old. She was first seen June 24. Two years ago, a sore appeared on the mucous surface of the nose, and was followed by ulcerating sores on its external surface. When first seen, the organ was twice its normal size, fissured, and warty-looking. The diagnosis was between syphilis and lupus. She was placed on the mixed treatment, and mercurial plaster applied; this was used for a month without much benefit; then pyrogalllic acid was employed locally from August until October, together with the mixed treatment, which caused the skin lesion to disappear more rapidly. In the beginning of October, the mixed treatment was discontinued, because it could not be tolerated by the stomach. After that, pyrogalllic acid, forty grains to the ounce, was employed, and early in November the nose was less than one-half the size it was when first seen. Now the patches are dry and scaly, and there are small tubercular spots, like lupus, which readily break down when the slightest force is employed. The question arises whether the pyrogalllic acid would have acted so well if the lesion had been syphilitic.

In a case of alopecia areata, which had been under treatment without benefit, he, after shaving off the hair, applied pyrogalllic acid, one drachm to the ounce. In five days there was decided improvement, and in a month quite a good crop of hair was growing. It may be that pyrogalllic acid has the power of destroying the parasite which Von Sehlen claims to have found in every case of alopecia areata, and to have succeeded in cultivating it.

The advantages claimed for pyrogalllic acid, used as a fixed dressing rather than in the form of ointment, were that it is much cleaner, easier of application, and that it excludes air and moisture, which, in some cases, might interfere with the cure of the disease, and it is not so apt to produce toxic effects as the ointment.

DR. FOX referred to a case of

#### ALOPECIA AREATA TREATED BY STATIC ELECTRICITY.

When the patient was first seen, two weeks ago, there were no signs of hair in the diseased patches. Within a week after the first application of electricity, a number of fine hairs had made their appearance.

## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

#### Impetigo; Its Contagious and Parasitic Nature.

DR. DEWÈVRE has just published in the *Archives de Médecine et de Pharmacie Militaires*, September 16, 1885, quite a lengthy memoir on the contagious and parasitic nature of impetigo. The contagious nature of this dermatose is shown to his satisfaction by both rational and experimental proofs.

*First. Rational Proofs.*—Most authors agree that scratching favors the dissemination of the affection in the highest degree. It appears especially upon the unprotected parts, in particular upon the face and about the mouth. It has a marked predilection for children and for those who have no regard for cleanliness.

*Second. Experimental Proofs.*—The clinical observations are numerous in which the transmission of impetigo has taken place to a healthy subject from one sick with the disease. Dewèvre cites in support of this statement the cases and works of Devergie, of Tilbury Fox, Wilson, Anderson, Taylor, Kaposi,



Neumann, Duhring, Piffard, Stellwagon, Van Harlingen, Wooster Beach, and others. The author reports seven unpublished observations of his own. On several of these patients, he has carried out such auto-inoculation experiments as Vidal had already done in 1877. Out of five inoculations, made with the contents of the vesico-pustule as soon as it was formed, he had one positive result. Out of five inoculations with the finely powdered impetiginous crusts, he obtained two positive results.

Out of five inoculations with the pus from beneath the crusts, there were four positive results, and when the product of scraping the ulceration, which had been previously cleaned, was employed, all five inoculations succeeded. All attempts to inoculate animals (guinea-pig, dog, horse, rabbit) failed. The pus and the products of scraping are the contagious elements *par excellence*. Clinical history and experimentation appear then to prove the inoculability and the transmissibility of impetigo from the sick to the well.

The parasitic element of this affection has been sought for. The author calls to mind the rather contradictory results arrived at by Kohn, Piffard, Geber, and Duhring, and believes that these differences of opinion can be explained by the fact that some have looked for the parasite in the crusts and others in the vesicles. Now the experiments of Dr. Dewèvre show that you must look for the parasite especially in the product of scraping of the ulceration after it has been well cleaned. In examining this product under the microscope, after suitable preparation, you find tufts of tubes of mycelium entangled together in such a way as to form a veritable network.

These tubes have a thickness of about three-thousandths of a millimetre, are readily colored, and show by transparency the spores with which they are filled.

The parasite seems to occupy the rete Malpighii. The author has made other experiments which would go to prove that the current of air passing over the impetiginous crusts can carry along with it morbid elements and produce at some distance an eruption of impetigo on an excoriated surface. Impetigo affects especially healthy subjects and it has a predilection for those recently vaccinated, as Dr. Piffard has already pointed out. Dr. Dewèvre thinks we should completely reject the opinion of many American and English dermatologists that there exist two distinct varieties of impetigo; impetigo contagiosa, and impetigo vulgaris. It is on the whole a very interesting paper, containing, however, some conclusions which need to be confirmed by subsequent research.

### Furunculosis.

In an excellent article which appeared in the *Bulletin de Thérapeutique*, Dr. Guigeot in a masterly way laid down the rational treatment of the furuncular affection. There are, according to him, scarcely ten years that we have had any exact notions on the real nature of the boil. It is a contagious affection which has twice been successfully inoculated (Lannelongue) and which appears to be caused by a vegetable parasite, *torula pyogenica* (Pasteur and Löwenberg). The evolution of this disease is completely modified by the nature of the soil on which it develops. Starting with these etiological propositions, Dr. Guigeot shows how little rational were the therapeutic methods formerly held in honor; early incisions, poultices, simple baths, local bleedings, etc.

Parasiticides must be employed as topical applications; the acid nitrate of mercury and carbolic acid have given good results, but the substance which the author has found by far preferable is the tincture of iodine. A thick application must be made to the whole part affected, encroaching upon the surrounding

healthy skin. The layers must be painted one upon another, until there is produced a staining of a dark-brown color. Unless this is done, the treatment may not succeed. You can thus obtain a complete resolution if you make the application early enough; in any case you will always greatly diminish the intensity of the pathological process. You should also paint with tincture of iodine all other cutaneous lesions which may develop in patients suffering from furuncles, for if this precaution is neglected, these may also become furuncular. If the employment of tincture of iodine on the face is objectionable on account of its color, it may be replaced by camphorated alcohol. Finally, if the case is a severe one, we have recourse to the acid nitrate of mercury or to carbolic acid.

The furuncles, after being opened, may be dressed with borated water or borated alcohol. Internally, the author advises the administration of the hyposulphite of soda dissolved in a large quantity of water, as Dr. Bulkley has used it; or the preparations of sulphur, which he considers much more efficacious. He uses habitually Pouillet's powder, of which he gives from twenty to eighty centigrammes per day, either in milk or in pure water.

Ordinarily, it is necessary to continue the medication by sulphur a month at least, and to take it up from time to time in obstinate cases to prevent relapse.

### Generalized Erythematous Exfoliative Dermatitis.

Dr. Thiry has communicated to the Royal Academy of Belgium (*Presse Médicale Belge*, Nos. 28-29, 1885) an interesting observation of the disease which, I believe, I first distinctly differentiated from the other morbid entities confounded under the term pityriasis rubra. Together with my excellent and much honored teacher Dr. Vidal, I gave it the name of generalized exfoliative dermatitis or disease of Erasmus Wilson. Dr. Thiry calls it generalized erythematous exfoliative dermatitis. His case relates to a man aged 25 years, who was attacked about the first of April, 1885, with sensations of weariness, lassitude, febrile movement, loss of appetite, followed by a red eruption which soon extended over the whole body, and then became covered with a continuously scaly desquamation. Between the 10th and 20th of May, all the hairs of the body, head, lids, eyelashes, and beard fell out. Toward the middle of June, the redness and desquamation disappeared almost completely. The disease, however, was still prolonged by the complications of a rebellious blepharo-conjunctivitis, abundant diarrhoea returning several times, multiple abscesses, pulmonary congestion, marked weakness, and loss of flesh, delirium, especially marked at night, gangrenous patches on the toes, and finally erysipelas, broncho-pneumonia, and innumerable abscesses during convalescence.

The patient was only able to leave the hospital the last day of August. Dr. Thiry follows the interesting observation by some considerations of the nature of this rare affection, but as he has confined himself, with the exception of a few unimportant details, to a repetition of what was already said by me in 1882, I will not dwell further upon it.

### Recurrent Scarlatiniform Erythema.

The last publication of Dr. Perret (*Lyon Médical*, Nos. 29, 30, 31, 1885) likewise treats of a subject to the elucidation of which, I believe, I contributed in a memoir which appeared more than a year ago in the *Archives de Médecine*. I was

indeed much astonished to see that Dr. Perret did not mention my work, and I can only believe that he was not acquainted with it when he wrote his article, for otherwise it would be altogether incomprehensible. As this memoir presents nothing new, but on the contrary omits important points, I would engage the reader who desires to gain further knowledge of the question to turn to the number of August, 1885, of this journal, where he will find in extenso the description which I have given of this affection.

### The Treatment of Keloid.

An interesting discussion recently took place, on the subject of keloid, in the Surgical Society of Paris, following the presentation of a case by Dr. Monod. The majority of the members who took part: Monod, Ledentu, Reclus, Berger, and Tillaux, opposed the total ablation of the tumor, largely done with the bistoury, because each time that they have practised this operation they have seen relapses follow. Drs. Lefort and Lucas championed the operation, believing that it should be done when the tumor is pediculated, voluminous, and when it greatly annoys the patient.

Dr. Reclus cited a case in which he had obtained great amelioration by local compression with mecurial plaster (*emplâtre de Vigo*), salt baths, and cod-liver oil in large doses internally. Dr. Ledentu and Dr. Berger also spoke of *crossed* linear scarifications carried out according to the method of Dr. E. Vidal. So far as I am concerned, I am convinced that this last procedure is by far the best, or if you prefer the least objectionable, only you must know how to apply it. Each week parallel linear incisions must be made through the whole thickness of the tumor, and passing beyond its borders, and these must be crossed at right angles by other similar incisions, in such a manner as to form little squares. According to my idea, these incisions should be as close together as possible, say two millimetres. In the intervals between the operations, *emplastrum de Vigo cum mercurio* should be kept constantly applied. I have already treated three keloids after this manner. In the first case, the tumor was very much reduced in size, but did not entirely disappear despite a great number of operations. In the second case, where we had to do with two keloid tumors of the right cheek, consecutive to caustic applications, eight scarifications have been sufficient to cause their disappearance, but I am keeping the patient under observation, expecting a recurrence of the disease.

The third case is one of enormous keloid, having a diameter of ten centimetres in all directions, and a thickness of one and a half centimetres, situated a little above the pit of the epigastrium. Here I have already done more than forty scarifications, obtaining a diminution of at least five-sixths of its thickness, but I am far from having produced a complete disappearance of the growth. One of the great advantages of scarification in keloid, an advantage upon which Dr. Vidal has insisted, is that of rendering the keloid indolent when it is causing suffering to the patient, which it not infrequently does.

### Treatment of Tinea Tonsurans by the Method of Fontis.

A fact which has struck me since I have been keeping up with the work done by Americans and English, is the facility with which you radically cure parasitic affections of the scalp, favus and tinea tonsurans, by the use of parasitocides alone without having recourse to epilation, while in France we obtain by your method only apparent and transitory cures. If we do not employ epilation, we always

have relapses. Then again, there is the treatment of Fontis (*British Medical Journal*, March 14, 1885) by frictions with the spirits of turpentine followed by applications of tincture of iodine, which has just been experimentally tried at the St. Louis Hospital by Dr. Hallopeau without the least success.

The conclusions of this author are that the treatment of Fontis does not cure tinea tonsurans in double the time claimed; that it is very painful, that its application is difficult, and finally that it excites a violent inflammation of the skin. Dr. Lailler, who has charge of the special service for these affections at the St. Louis hospital, has met with the same results.

### Resurrection of Blennorrhagia and the Value as a Parasiticide of Corrosive Sublimate Injections.

At the Congress of Grenoble of the French Association for the Advancement of the Sciences, Dr. Diday remarked upon the curious fact of observation that when a gonorrhœa, treated at a seasonable time by copaiba, does not completely cease if the medicine be stopped, we see the running appear again at the end of a couple of days and become more abundant than before the use of the balsam. He gives the following explanation: The specific medication diminishes the nutritive qualities of the soil on which the gonococcus flourishes, but if you cease to employ the copaiba before the complete disappearance of the microbes, they again find a urethral soil favorable to their growth, and complete their development.

Dr. Constantin Paul believes that the best means of curing gonorrhœa consists in giving injections of corrosive sublimate at a temperature of 104° F. Dr. Spillman, on the other hand, has found no advantage arising from the method, as his patients could not bear the injections. Besides, Drs. Sinety and Henneguy have made experiments on the gonococcus of blennorrhagia, the result of which seems to be that permanganate of potash, oxygenated water, and corrosive sublimate exercise no specific action upon these micro-organisms.

### Nature of the Chancroidal Bubo.

I have already made known, in one of my previous letters, the researches of Dr. Strauss on the virulence of the chancroidal bubo. Having had the fortune to meet with a lucky series of cases, this author concluded that the buboes which accompany the simple chancre are never of themselves virulent, but only become so after being opened and becoming inoculated by the pus of the chancroid itself. Dr. Geiny (*Annales de Dermatologie et de Syphiligraphie*, Nos. 8-9, 1885) has again taken up this question. He has made twenty inoculations with the pus of the chancroidal bubo, with all possible antiseptic precautions, and has obtained four positive, three doubtful, and thirteen negative results. He believes, therefore, that he ought to support Ricord's old theory, according to which the adenitis which accompanies a soft chancre is, in three-quarters of the cases, purely inflammatory. In the remaining one-quarter of the cases it is produced by the transfer of the micro-organism, the infecting agent, by the route of the lymphatics to the ganglion which becomes a chancroidal bubo. Dr. Strauss himself has returned to his former opinion. In a more recent communication, made to the Society of Biology, he presented new statistics showing that, out of 118 buboes recently inoculated in different hospital services in Paris, 6 were followed by positive results and 112 failed. The proportion of virulent buboes appears then to be smaller than the statistics of Ricord would indicate.



### Treatment of Chancroidal and Syphilitic Phagedenism.

At the Congress of Grenoble of the French Association for the Advancement of the Sciences (*Semaine Médicale*), Dr. Spillmann, of Nancy, described a new method of treatment of phagedenism, both syphilitic and chancroidal. Believing that the phagedenic process is due to a peripheric infiltration of young elements and of colonies of microbes which compress the vessels, and thus disturb the vitality of the tissues, he thinks that treatment should have for its object the destruction of all infiltration capable of impeding the circulation, and to replace the phagedenic by a healthy wound. He also practises scraping the ulceration with the sharp spoon in all cases, and cuts off the overhanging borders with curved scissors; he then cauterizes with the thermo-cautery, and dresses the wound with a solution of corrosive sublimate, one to two thousand.

### Lesions of the Buccal Mucous Membrane in Lichen Planus.

Dr. Ehibierge, in *Annales de Dermatologie et de Syphiligraphie*, treats of lesions of the buccal mucous membrane in lichen planus. Erasmus Wilson had observed small, white spots on the tongues of two of his patients. Hutchinson has noticed the same complication in two cases; Radcliffe Crocker has described them minutely; lastly, Pospelow and Neumann have each published an example of the kind. Dr. Ehibierge reports three very complete cases, and appends an accurate account of the symptoms. According to him, lichen planus may invade the buccal mucous membrane at an uncertain stage in its evolution—before, during, or after the cutaneous eruption. Usually, the membrane merely feels rough, without any pain, and the patient is only by accident made aware of the complication. In most cases the lesions are seated on the tongue and the internal surface of the cheeks; on the tongue they appear as round or irregularly-shaped white spots, not at all elevated, either solitary or united, and in the latter case forming parallel lines at the edges of the organ; on the cheeks they take the shape of small, pointed, round or stellated pimples, very white, sometimes shining, and either solitary or united, and forming patches, large or small, which may be scattered over the whole surface of the cheek, or, when extending far enough, may occupy the posterior portion in the vicinity of the last molars. Their occurrence upon the buccal mucous membrane is favored by local irritation of any sort; they persist for a longer or shorter time, but their tendency is always towards improvement, if not a complete cure.

### Urticaria Pigmentosa.

M. Feulard describes, in *Annales de Dermatologie*, a case of that curious affection which has been the subject of observation in England and America, under the name of urticaria pigmentosa. It occurred in the person of a little girl 19 months of age, and began when she was 4½ months old, by an eruption of large red pimples and whitish blisters, accompanied by very troublesome itching. This eruption was first noticed on the abdomen, whence, in the course of about a year, it gradually spread over the entire surface, and finally upon the face. When first seen by the author, the body was completely covered with brownish spots, varying in depth of tinge from that of *café au lait* to that of copper; in some places they were separately scattered, round or oval, and as large as a lentil or a fifty-centime piece; in others, confluent and forming irregular blotches. Their outline was plainly defined; they were slightly elevated, and when pinched between the fingers

imparted a sensation as if the derma were somewhat thickened. This was quite well marked in the case of the recent patches, which, under friction, would assume the exact appearance of nettle-rash. Older patches had a roughened aspect. In short, the disease was characterized by the production of urticarial patches, which underwent a gradual pigmentary change. The child was well developed, and its general health was perfect. The disease had apparently been growing less intense for several months past. While it remained under the author's observation (*i. e.*, during the year 1884) he could see that the urticarial patches became much less numerous, that those which were formed underwent no pigmentary change, and that the old patches by degrees flattened and faded. I have myself met with two other cases of urticaria pigmentosa, in the respective services of Professor Fournier and Dr. E. Vidal. M. Fournier's little patient was only a few months old, and had suffered from the malady almost from her birth. In many places the eruption was of a bullous nature; in others, unmistakably urticarial. M. Vidal's patient was older; he presented every degree of the eruption, and his case was particularly worthy of study; a very minute description of it will be soon published. Since examining this latter subject, I have been better able to appreciate the propriety of the designation urticaria pigmentosa, or xanthelasmaidea, which has been bestowed upon this singular skin disease; in fact, the older lesions which it presented upon the face and neck appeared precisely similar to the elements of xanthelasma tuberosum.

### Colloid Degeneration of the Derma.

As likewise dealing with an affection of rare occurrence, I will call your attention to an article by MM. Feulard and Balzer on colloid degeneration of the derma. The subject of their investigation was a gardener, 40 years of age. In July, 1878, small yellowish blisters, slightly elevated, arranged in clusters, non-exuding and non-pruriginous, made their appearance over his left malar bone. In January, 1880, they extended to the other cheek, then to the bridge of the nose, and finally to the forehead. When first examined at the hospital, the eruption was scattered over the whole face, but was especially abundant at the above-mentioned localities. The affection is characterized by small, shining blisters, of a lemon-yellow color, of the size of a pin's head or of a millet seed; they appear transparent and as if full of serum, but after pricking them only a sort of yellowish jelly can be squeezed out. They impart to the skin an appearance as if grained. Histological examination has shown that this lesion is due to an infiltration of the derma by variously-sized lumps of colloid matter, generally situated in the spaces which separate the pilosebaceous structures. They do not come into contact with the epidermis, but remain divided from it by a delicate layer of normal connective tissue. This colloid infiltration seems to invade at first the conjunctive fascia of the derma, causing them to swell up and unite together into compact masses of different dimensions, which push back the surrounding healthy tissues. It forms in this way a sort of cellular deposit, which may be enucleated, as it were, by scraping. This, in fact, is the best mode of treatment. It is carried out, at one or more sittings, by the use of a small sharp-edged curette.

L. BROCCQ.

PARIS.

## Selections.

---

### THE SURGICAL TREATMENT OF CHRONIC ECZEMA.

THE surgical treatment of chronic eczema has, of late years, been frequently recommended without having met with special approval. This has been chiefly owing to the defects of the proposed methods, whose results have not been such as to tempt us from the usual path of medico-mechanical treatment. It is always possible, although only after a long treatment, and frequently after the occurrence and removal of several relapses, to cure chronic eczema completely, and without any tissue-lesion, by the use of medicinal and mechanical remedies; the affected integument returning more or less completely to its normal state and function.

In comparison with this uniform success attendant upon a skilful and persevering management, the result of a method whose object it is to substitute a single cicatrix in place of the whole eczematously-affected surface is no more entitled (as Auspitz remarks) to be called a cure of the eczema than the deep cauterization of a catarrhal mucous membrane, with resulting cicatrization of that structure, can be regarded as a cure of the original complaint.

This criticism is applicable to both of the methods which have been hitherto pursued in the surgical treatment of eczema. In that recommended by H. von Hebra, the affected tissues, in certain forms of the complaint, are removed by the sharp spoon, so as to leave in place of the eczema an ulcerated surface, followed by a cicatrix. In Vidal's process, the same result is brought about by means of multiple and repeated scarification of the eczematous integument. I have made trial of both these methods in one and the same case, with results which were unsatisfactory, both as regards the permanency of the cure and the character of the cicatrix.

Each of these measures, like every other surgical process in the treatment of chronic eczema, can only be employed when the affection is trifling in its extent, and confined to covered parts, *i. e.*, in circumscribed chronic eczemas of the trunk and extremities. In this kind of eczema, when long-lasting, and presumably liable to relapse even after persevering medico-mechanical treatment, a surgical procedure that effects its object in the shortest possible time is fully justified, provided only it be so conducted that the title of a genuine "cure of eczema" cannot be denied to its results. In order to satisfy this requirement, it must consist, not simply in a forcible removal of the diseased surface, the substitution of a sore, and the complete cicatrization of the latter, but, by keeping up the bleeding from the skin as long as possible, it must do away with both the cause and the product of the chronic inflammation.

This much is certain, that every patient will gladly prefer a process of cure which, within two weeks at the farthest, effects the permanent removal of an obstinate and relapsing eczema, and that with but a trifling amount of cicatrization, a process, moreover, involving infinitely less trouble and annoyance than the medico-mechanical treatment.

After numerous experiments in this direction, I have contrived a mode of operation similar in principle to that of Vidal, but effecting its object in a differ-

ent way, which has given excellent results. This I will now proceed to describe.

The affected portions of skin which are to be treated should not be of greater extent than can be completely covered by the hand. After any eczematous crusts which may be adherent to them have been thoroughly removed by warm water or oil, the entire diseased surface is scarified. The scarification is performed with a small, very sharp double-edged lancet, such as is employed by oculists. With this, vertical and horizontal—i. e., rectangularly intersecting—incisions are made, running parallel to each other at intervals of about seven millimetres, and consequently dividing the surface into squares of the same measurement. The incisions must be made pretty deep, their depth in each case depending upon the thickness of the chronic inflammatory products in the cutis. The more compact and harder the affected skin, the more forcibly and deeply must the incisions be carried. The bleeding from them is inconsiderable, and is easily arrested by compresses. When it has been somewhat stanchd, the whole of the incised surface is covered with a layer of officinal caustic potash. This is well rubbed in with a brush of wadding or of charpie, until the superficial horny layer of the individual skin-squares begins to loosen. The potash is then carefully washed off from the incised places, which are dressed with Hebra's ointment or olive oil. The caustic potash has been rubbed into the incisions, over which it forms, along with the blood, a black eschar extending in straight lines. Previous to the operation, a subcutaneous injection of morphia is administered to the patient, and the affected surface is anesthetized with ether by means of an atomizer.

The dressing of ointment or oil is suffered to remain for twenty-four hours; when it is removed, the little skin-squares are found to be mostly denuded of their superficial epidermic layer. Water-dressing now takes the place of the ointment for another twenty-four hours. When it is removed, the entire eschar is found to have fallen off from the linear scarifications, and in its place are longitudinal sores which encroach on the outlines of the individual skin-squares to the breadth of about one millimetre. In this way the skin-squares themselves have become somewhat smaller, and have lost their rectangular shape, assuming one which is rounder or more irregular; their horny epidermis is entirely removed, and the moist and exuding mucous layer is exposed to view. The portion of skin which has been operated upon now looks like a raw surface, covered with a great number of transplanted pieces of skin, so closely crowded together that the granulations of the sore are scarcely visible between them. Remedies which promote the formation of cuticle, such as solution of nitrate of silver or pyrogallic ointment, are now applied to this surface; these dressings are changed every three days. In from ten to fourteen days, all eroded and ulcerated places are completely skinned over, and the chronic infiltration has partly disappeared, partly in process of disappearance, entire absorption taking place without further treatment before another fortnight has elapsed. The previously diseased surface now affords an interesting spectacle: The numerous skin-squares are light-red, partially desquamating, and inclosed by linear cicatrices, dark-red, shining, and scarcely one millimetre in breadth. The whole has a reticulated appearance; the fine, dark-colored cicatricial lines surrounding the portions of sound skin with a symmetrical border, like a bright network. The eczema is cured. After several months the appearance just described is altered. The fine cicatricial lines have become white, and the skin-squares have regained their normal color, elasticity, and function. Without noticeable disfigurement, with-



out alteration of its level, without loss of its physical condition or its physiological activity, merely crossed by a number of fine linear cicatrices, the formerly eczematous surface has been restored to health. Here and there, in a very few places only, has one of the little squares of skin been transformed into a fine, delicate cicatricial structure. A trifling amount of scaliness which appears upon these squares after their epidermis is completely restored, is speedily removed by inunctions of oil. The cure so rapidly effected is, moreover, a permanent one. Relapses never occur, even when the eczema thus treated is seated upon the bend of a joint, the operation exerts no influence upon the elasticity and pliability of the skin.

It should be observed that some practice was necessary before I attained complete success in this procedure. In the first case in which I employed it, the incisions were not made deep enough, and the cauterization was not performed with sufficient energy, so that afterwards I was obliged to have recourse to tar, in order to effect a permanent cure. In the second case, I scarified and cauterized too forcibly, and consequently got superficial cicatrices in some places. It was not until the third case that I obtained perfectly satisfactory results.

The cure of a chronic eczema is accomplished by this surgical method in the following manner: 1. The masses of thickened epidermis are removed by the caustic potash. 2. Most of the blood-vessels which supply nourishment to the product of the chronic inflammation in the cutis are severed by the scarification, and to a certain extent destroyed by the caustic potash, in consequence of which it becomes atrophied and is absorbed. In this way the inflammatory product is necessarily caused to disappear from among the skin-squares. 3. In the incisions themselves and their immediate vicinity—*i. e.*, in the periphery of the skin-squares—the chronic infiltration is removed by an opposite process, as follows: As a result of the trauma and of the cauterizing, lively inflammation is developed, accompanied by the formation of linear sores; new vessels are produced in the granulations, causing a more active circulation of the blood, by which the infiltration is washed away and disappears. Of course, not *all* the blood-vessels leading to the skin-squares, though certainly the greater part of them, are destroyed by the scarifications, otherwise the absorption of the infiltration would give rise to a single superficial cicatrix, as in Vidal's method. It is possible that, along with the formation of new blood-vessels in connection with the linear sores, new capillaries are also supplied to the bordering, peripheral portions of the skin-squares.

It is thus evident that the designation of "a cure for eczema" cannot be denied to this mode of treatment, since the diseased integument is almost wholly restored to its normal condition, only an exceedingly small portion of it being transformed into cicatricial tissue. This operative procedure accomplishes with more speed and certainty, by a shorter, or, if you please, a more direct route, precisely what is also brought about through a correct and persevering employment of the alkaline spirit of soap, tar, etc.

This surgical method of treating chronic eczema is indicated, as we have already said, solely in cases of circumscribed eczema of the body and of the extremities, with the exception of the hands. It may be resorted to without hesitation in chronic circumscribed eczemas of the bends of the joints, since it involves no risk whatever of lessening their mobility from cicatricial contracture. The superiority of this surgical treatment of eczema becomes more clearly apparent, and is also more correctly estimated by the patient, if the disease is of very long

standing, and especially if it has relapsed frequently, even after skilful medico-mechanical treatment.

I have also employed this method of scarification with advantage in chronic eczema of greater extent, by confining its application to small isolated places where the disease was most pronounced, *i. e.*, where the infiltration was greatest. The following is a case of this kind briefly reported:

M. K. von R., widow, æt. 63 years, had suffered for six years with chronic eczema of the inner surface of both thighs, which had been treated frequently, but without lasting success. The starting-point of the disease was a place as large as the palm of the hand in the middle of the right thigh; here the epidermis and cutis were thickest and reddest. There was a similar spot as large as a five-mark piece on the corresponding locality of the left thigh. May 3, 1884, the former of these patches was scarified and cauterized. The other one, on the left thigh, was not scarified, but merely softened with potash. The remaining portions of the affected integument were then treated with spirit of soap and Hebra's ointment, afterward with white precipitate ointment and tar. May 14, 1884, the scarified place on the right thigh is cured. June 20, the disease has disappeared everywhere else excepting from the spot on the left thigh, which is still scaly and infiltrated. In the beginning of July this too was well. In September, a relapse occurred in this latter situation in the form of a papulo-squamous eruption of which at first the patient took little notice. At the end of September, the renewed infiltration having made considerable progress, the seat of relapse was scarified and cauterized. Complete recovery took place in ten days, since which time there has been no return of the complaint.

In two other cases besides this, of non-circumscribed chronic eczema, I have scarified small places that were the most infiltrated, with the same favorable result. One was a case of chronic eczema of the dorsa of both hands, the other of chronic eczema of both nates. These partial scarifications shortened the duration of the whole treatment, and increased the probability of a permanent cure. —MAX BOCKHART, *Deutsche Med. Wochenschrift*, July 16, 1885.

## ON SYPHILITIC STRICTURE OF THE TRACHEA.

SYPHILITIC affections of the trachea may be classed amongst the rarer forms of syphilis. They may occur both in congenital and acquired syphilis, and in the latter may be observed both in the earlier and later stages of syphilis. In the earlier stage of syphilis we meet chiefly with tracheitis, condylomata, and mucous plaques. These affections give rise to no grave symptoms, and yield soon to treatment. The lesions which are found associated with the later stages of syphilis are, however, much more serious, and often lead to death. These lesions are either gummous tumors or, much more commonly, syphilitic ulcers with surrounding infiltration, which by their cicatrization lead to stenosis of the trachea; or, by an extension of the ulceration, there may be perichondritis, necrosis of the cartilage rings of the trachea, with contraction and displacement of the trachea or perforation of the tracheal wall, with abscess formation in the mediastinum; or again, especially if the ulcer is situated in or near the bifurcation and involves also the large bronchi, there may be rupture into the pulmonary artery (Gerhardt, *Deutsches Arch. f. klin. Med.*, Vol. II., p. 541; Kelly, *Trans. of Path. Soc.*, Vol. XXIII., p. 45); or into the arch of aorta (Wilks, *Trans. of Path. Soc.*, XVI., p. 52). In most cases, however, death has resulted suddenly after the symptoms of tracheo-stenosis had existed for some time.

The symptoms produced by syphilitic disease of the trachea vary with the situation and extent of the ulcerations, and with the presence of syphilitic disease in other portions of the respiratory tract, especially in the larynx. In an analysis by Vierling (*Deutsches Arch. f. klin. Med.*, XXI., p. 325) there was an affection of the larynx in thirty out of forty-six cases reported; in sixteen the trachea, with or without the bronchi, was found affected; while in five the bronchial mucous membrane was the only part attacked.

The diagnosis of tracheal syphilis presents no difficulty when the larynx is also affected, and when there are other syphilitic symptoms. If, however, the trachea alone, or the trachea and the bronchi are affected, the symptoms are those of stenosis, and the differential diagnosis between syphilis of the trachea and some mechanical compression of the trachea, either from an enlarged gland, a small intra-thoracic tumor, or an aneurism of the arch of the aorta is not always easy.

The most prominent symptoms of tracheal stenosis are :—

1. Dyspnoea, most marked during inspiration, and especially so on any exertion of the patient. This, though a most prominent symptom, may occasionally be absent, though the obstruction to the entrance of air into the lungs may be very great, as in a case reported by Beger (*Deutsches Arch. f. klin. Med.*, Vol. XXIII., p. 608), where there was most marked narrowing of the bifurcation and of the bronchi by a gummous tumor.

2. A hoarse, weak, or croupy voice, even if the larynx be free from disease, due to the weak air current.

3. Swelling of the jugulars with every expiration, due to the abnormally increased pressure in the large veins within the thorax during expiration.

4. Slight downward movement of the larynx with every inspiration. This movement is much more considerable in stenosis of the larynx (Gerhardt).

5. The patient breathes easier with his chin depressed, as this causes relaxation and dilatation of the trachea. In laryngeal stenosis, on the other hand, the head is thrown back to facilitate the breathing (Gerhardt).

6. Retraction of the lower part of chest with every inspiration.

7. Loud inspiratory stridor, heard best over the sternum, occasionally accompanied by a thrill, to be distinctly felt over the place of constriction. Auscultation of the lungs reveals weak breathing and loud rhonchi, unless here be some lung complication. It often happens that the stricture is at the bifurcation of the trachea, and extends to one bronchus rather than to both. In such cases we have the characteristic symptoms of stricture of a bronchus (diminished fremitus, diminished breathing, and more marked inspiratory retraction of the ribs) on that side.

8. The laryngoscopic examination may enable us to see the affected part, especially if the stricture is high up in the trachea or if the ulceration is extensive; and the introduction of sound through the larynx, recommended first by Demme, *Wien. med. Zeitschrift*, 1861, p. 441, may, in doubtful cases, assist us in our diagnosis. In spite of these definite symptoms, the diagnosis between syphilitic stricture of and pressure on the trachea is sometimes a matter of great difficulty.

*Treatment.*—I would suggest in such cases the gradual dilatation of the constricted part or parts. This could be done either through the larynx—and, according to several observers, a sound may easily be passed between the vocal cords into the trachea without much distress to a patient—or, better still, directly through the trachea, after having previously performed tracheotomy. This mechanical treatment should be combined with an anti-syphilitic treatment to check the further

extension of the ulceration, and to prevent the further troubles, such as necrosis of cartilages, abscess formation, etc., only such treatment should not be too energetic, so as not to cause a too rapid cicatrization, for the slower the narrowing of the lumen takes place, the more likely will there be a gradual accommodation of the lung to the altered condition.—DRESCHFELD, *Medical Chronicle*, Dec., 1885.

### OBSERVATIONS ON ECZEMA.

DELIGNY defines the anatomical lesion in eczema as an epidermo-dermatitis of a special nature. It is not an inflammatory lesion, such as can be produced artificially by irritation of the skin. It is a special inflammation, for it has a special evolution, at one time a moist, at another a dry catarrh, facts not observed in artificial dermatitis. This is an important point which is not admitted by the German school, but which can be deduced from clinical observation. Speaking of the causes of eczema, he says: Diabetes not only produces a genital eczema, but also eczema of other parts of the body; in fact, the skin acts badly in diabetic subjects, it is habitually dry, perspirations are rare, and when they do occur, they eliminate a certain quantity of sugar, an incessant cause of irritation for the integument. At one time this results in a pruritus, one of an intense character, and generalized, to which attention has been called by Hebra, Garrod, and Siegen. At another time it leads to erythema, lichen, and eczema. On the diagnosis between eczema of the scalp and pityriasis, he observes: Many persons exhibit permanently, from the age of 10, 15, or 20 onwards, a desquamation of the scalp which they and certain physicians regard as a pityriasis of the scalp. Most frequently it is not so, but an abortive eczema. That which is a pityriasis of the scalp is a desquamation consecutive to a seborrhœa there, under the form of fine grayish-white micacious scales, resembling bran, which causes falling off of the hair. Eczema may persist on the scalp for years without implicating the hair; and this eczema of the scalp, which we may call like pityriasis (in giving to the word pityriasis a precise signification), does not cause baldness. This is an important distinction, and one which, unless borne in mind, may lead to inconveniences from the treatment adopted. Most frequently, indeed, the affected person intrusts himself to the care of his hairdresser. This is of no moment if he has a seborrhœa, as cleanliness is always useful in that; but if he has eczema, it becomes worse under such treatment. Amedie Latour has related in the *Union Médicale* the harm done to his scalp in such circumstances. Borax is the best application in scaly eczema of the scalp, not only in cleansing the head, but in arresting the desquamation. Michle recommends:

℞ Boracis. ....	grs. 150.
Alcoholis,	
Aq. Rosæ.....	āā ʒ iv.

Boracic vaseline is an excellent preparation which is often employed at St Louis.

℞ Acid Boracic. pulv.....	ʒ iss.
Vaselini.....	ʒ i.
Bals. Peruv.....	grs. viij.

The tincture of benzoin and the balsam of Peru are used in virtue of their stimulant action. Enveloping the parts in india-rubber coverings renders great service in all crusted eczemas, above all in eczema of hairy parts. It is econom-



ical, and replaces poultices in extensive eczemas. The direct contact of the sheet of india-rubber with the skin, and particularly with the diseased surface, is not always well borne by every one. Besnier, therefore, modifies it as follows: He dips bands of muslin in starch water, prepared by adding a teaspoonful of starch to a quart of water. He surrounds or covers the affected part with two or three folds of thin muslin, above this he puts the india-rubber sheeting. If the secretion is fetid, he adds to the starch water boracic acid in the proportion of 75 grains to the quart. When all inflammation has disappeared, he recommends to add 1 grain per 1,000 of sulphate of copper, to hasten the cure. Sulphate of copper is little used in dermatology, and this is a mistake, since its use is the cause of nearly all the success of the quacks who treat skin diseases. One per thousand in solution causes no inflammation. Prolonged rest in bed is in some cases a useful adjunct in the treatment of eczema. The recumbent position may be maintained for fifteen to eighteen hours out of the twenty-four. It is particularly serviceable in eczema of the limbs, where walking and fatigue might aggravate the inflammation, and it is useful, also, in very extensive eczemas.—*L'Eczema* (par Dr. L. Deligny), Paris, 1885. *Ed. Med. Journal*, Nov., 1885.

### THE LOCAL TREATMENT OF PSORIASIS BY CHRYSOPHANIC ACID.

IN only one instance among the seventeen cases cited in this essay—making allowance, that is, for intervals of time during which the frictions were suspended, owing either to a failure in the supply of drugs or to the supervention of conjunctivitis—was treatment continued longer than a month; with many patients it lasted only half that time, and some required but four or five applications.

The single case which proved refractory remained, it is true, a long time in the hospital, but this was because he was six weeks in another service, which he left uncured; moreover, a fresh outbreak of the disease took place under our own observation, upon the very locality of the first attack.

That the remedy under consideration has not the property of preventing relapses is proved by the fact we have already mentioned, that it is only adapted to remove the existing cutaneous symptoms, and hence in cases of psoriasis, which may be denominated a perpetual disease, the struggle will sometimes have to be maintained indefinitely, if we would not leave the malady to conquer in the end.

This want of power to prevent a return of the complaint is clearly displayed by several of the cases above referred to, in which, after all the psoriasis-patches had disappeared, new papules were seen to arise.

Our most speedy cures have been effected among out-door patients in regular attendance, these being less severely affected than the hospital subjects.

Our treatment of psoriasis does not consist wholly in the application of medicated plasters. These may be sufficient for mild cases; in those of a different character we have the patient take a bath of starch every two or three days, either at the commencement of his treatment or throughout its continuance. This is of service by promoting the detachment of the more superficial psoriasis-crusts, and thus facilitating the action of the medicine; subsequently also it has the effect of subduing the erythematous inflammation in the neighborhood of the patches. Moreover, when the disease is extensively diffused, we confine our applications to a single portion of the surface, in order to test the patient's susceptibility to the drug, before rubbing it in all over him. From the latter process no unfavorable constitutional results are to be apprehended, because, 1st, chrysophanic acid is

not poisonous, and, 2d, it is not absorbed. Microscopical examination has failed to detect it in the urine; nor has this secretion, in the case of our patients generally, yielded the slightest trace either of chrysophanic acid or of albumin. The treatment we are describing may therefore be regarded as absolutely harmless.

On comparing the average periods of time required for the cure of psoriasis, as laid down by the authorities, we find that the arsenic treatment takes three or four months; that by oil of cade, from six to eight weeks; pyrogallic acid, four or five weeks; while chrysophanic acid does its work in a fortnight or three weeks—at farthest, in a month.

Relying upon these considerations, we have not the slightest hesitation in assigning to chrysophanic acid, employed in the form of plasters, the foremost place among the local remedies for psoriasis.—A. DÉROBERT, *Thèse de Paris*, 1884.

### XERODERMA PIGMENTOSUM.

PROF. KAPOSI presented before the Society of Physicians, of Vienna, at the meeting of October 23d, 1885, the case of a girl aged 9 years, affected with xeroderma pigmentosum. In the region of the face, the nose, and the eyelids, were present multiple carcinoma nodes and warty formations, in a favorable condition to be transformed into epithelial cancer.

Kaposi first described the nature of this disease in 1870. It is met with in early life, beginning as a rule at the end of the first year or during the second year of childhood.

There usually appear upon the face, the backs of the hands, and upon the palms, smooth pigment spots of either a light or dark-brown color, resembling lentigo or freckles. These spots in later years spread over the region of the neck, arm, forearm, back of foot and leg, in greater number and wider distribution.

The process first assumes the features of a separate and distinct disease when atrophy begins. Small white spots are now noticed which are free from pigment, smooth, and like cicatricial tissue, covered with thin wrinkled epidermis. The skin now becomes decidedly thinner, parchment-like and shrunken, so that the nose appears pinched and shortened, and the openings of the eye, the nostrils and the mouth, seem contracted. Finally, multiple carcinoma and often sarcoma, and malignant papilloma appear, and in many cases this complication has been the cause of death.

Up to the present time, thirty-eight cases of this disease have been published. These are collected and tabulated by Prof. Kaposi.

The table shows that several children of a family are, as a rule affected, and with two exceptions those observed up to the present time have been children of the same sex in each family. The youngest patient was five months, and the oldest forty years of age. The sex was about evenly divided; there being twenty females and eighteen males. The largest series of observations in one family is reported by Rüder, who saw seven brothers thus affected. The other cases are mostly in groups of two or three brothers or sisters. It is much to be desired that the relationship between melanosis and multiple carcinoma and sarcoma be arrived at.—*Wiener Medizinische Wochenschrift*, No. 44, 1885.

### CHROMIDROSIS OR CHROMOCRINIA.

At a recent meeting of the Academy of Medicine of Paris, Dr. Féréol communicated an observation of Labourdin, an accomplished pathologist, on a case of chromidrosis, or, as he prefers to call it, chromocrinia.

The observation was verified by Dr. Féréol himself and Dr. Rochard.

The subject was a young woman, of about twenty years of age, who suffered at times from violent attacks of convulsive hysteria, and from neuralgia. In February last, a blue discoloration was first noticed on the lower eyelids. At first it was not very intense, and varied from day to day. It became very marked under any nervous excitement, and merely speaking of it to the patient would suffice to bring it out.

The same discoloration was found over the sternum, in the inter-mammary region, and in both axillæ. There was scarcely a trace of perspiration. The possibility of fraud was excluded, and the patient greatly desired relief. Microscopic examination of the coloring-matter showed all the peculiarities described by Ordoñez. The fragments of coloring-matter closely resembled the scales resulting from the fracture of dried Canada balsam.

Dr. Féréol insists on the absence of sweat in nearly all cases of observed chromidrosis, and thinks it would be justifiable to use the name *chromocrinia*.

Three cases of *yellow chromidrosis* were reported by Dr. Tison at the Paris Academy of Medicine, in December, 1884.

Three servants in the same family were affected at the same time with a bright yellow discoloration of the neck, back, and chest, sharply defined. The coloring-matter was secreted more abundantly when perspiration was free, and continued to appear for two and a half months.

No cause for simulating could be found.

There was no sign of jaundice.

Dr. Méhu held that the material consisted of sulphur, but this point was not definitely settled. Occurring as it did in three men in the same house, it would appear as though due to some common external cause, and not the disease usually seen in hysterical women.—*Bulletin de l'Acad. de Médecine*.

## TREATMENT OF THE SCROFULOUS DIATHESIS.

For the treatment of the scrofulous diathesis, M. Guibout particularly recommends the use of iodine, either in the form of iodide of starch, giving ten to fifteen grams a day, or as iodide of potassium, with or without the addition of the tincture of iodine. A favorite prescription with him is:

℞ Mucilag. gum. acaciæ .....	150 grams.
Potass. iodidi.....	2 “
Tinct. iodini.....	10 to 15 drops.
Tannin....	1 gram.
Syr. of cinchona.....	30 grams.
M. Sig. To be taken in three doses during the day.	

With the iodine, it is best to make use of cod-liver oil, iron, cinchona, mineral waters, and strong wines. The patient is to be put in the best hygienic surroundings, such as fresh air by the seashore, the use of baths, gymnastics, rich, nourishing animal diet, and frictions of the skin. If the appetite or digestion becomes sluggish, it is to be stimulated by bitter stomachics before meals, and by saline purgatives from time to time.

For the destruction of scrofulides (such as lupus), one of three plans may be adopted: 1. Apply to the diseased patch an ointment composed of fifteen grammes of the biniodide of mercury and thirty grammes of fresh lard, to be left on for twenty-four hours. This will produce a pustular eruption. In time, with

successive renewals of the ointment, the scrofulide will be destroyed. 2. Multiple punctures or scarifications. 3. The thermo-cautery, using the Paquelin.—*Gazette Médical des Hôpitaux*, No. 79, 1885.

### TREATMENT OF ECZEMA.

FOR the treatment of eczema, M. Guibout recommends in localized acute eczema poultices of potato starch made quite moist, applied almost cold, and renewed three times in twenty-four hours; lukewarm bran or starch baths; lukewarm lotions; avoidance of all local irritation and friction. When eczema attacks the scalp, he orders the hair to be cut off (a generally unjustifiable proceeding, in my judgment, and to be especially avoided in women). When the face is attacked, he covers it with a mask of potato starch or of vulcanized rubber, leaving apertures for nose, mouth, and eyes. If the disease appears on the genital region, he insists upon the horizontal position being preserved by the patient, and when it attacks the legs, they must be kept elevated, and never allowed to hang. When the eczema is universal, vulcanized rubber garments are to be worn constantly, and changed every twenty-four hours. If these cannot be had, white-wash the body with a mixture of equal parts of oil of sweet almonds and lime water, and powder the surface with starch. With this, a bath of bran water is to be taken every day, or second or third day.

In chronic eczema, more stimulation is needed, such as sulphur vapor baths, alkaline baths, smearing the part with oil of cade, frictions with green soap, lotions of bichloride of mercury, one part in five hundred of dilute alcohol, or an ointment of boracic acid, ten grams, in vaseline, one hundred grams.—*Gazette Méd. des Hôpitaux*, No. 85, 1885.

### CONTAGIOUSNESS OF VARIOLA AT THE BEGINNING OF THE ERUPTION.

LANCEREAUX reports three cases occurring in his hospital service, in which small-pox was transmitted at the beginning of the eruption. From these facts he draws the conclusion that variola may transmit itself on the first or at least the second day of the eruption, since the small-pox patient admitted by mistake in the hospital was transferred two days after the appearance of the eruption. This is, however, not the opinion commonly admitted. An English physician of great celebrity, Herberden, following the citation of Dezateux and Valentine, asserted that he was in possession of facts demonstrating that small-pox could not be communicated until after the second or third day of the eruption, and that persons who had never had it might, up to this period, sleep with those who had it without risk of taking it.—*Bul. de l'Académie de Médecine*, Sept., 1885.

### PERFORATING ULCER OF THE HAND.

At a recent meeting of the Surgical Society of Paris, M. Terillon presented a mould of a case of perforating ulcer of the hands. The disease was similar in every way to the perforating disease of the foot.

Healing rapidly took place when the hands were not used, but when the patient returned to work the ulceration began again. The subject was a male, 25 years of age, syphilitic and tabetic. All the symptoms of locomotor ataxia were present, and there was complete anæsthesia about the ulcerations. A central trophic lésion of the upper part of the spinal cord was suspected.



M. Terillon had presented a similar case at a previous meeting.

M. Trélat stated that he had seen the ulcers upon the hands and feet at the same time, in a patient who was ataxic.—*Revue Médicale*.

### THE TREATMENT OF LUPUS BY ARSENIC.

To discover just what influence the internal administration by arsenic without any local therapy whatever has upon the evolution of lupus, Lesser (*Centralblatt für die Med. Wissensch.* No. 7, 1885) administered it in five cases. He used in his observations Asiatic pills, and at times subcutaneous injections of Fowler's solution.

In one case there was no beneficial result, but in the other four a decided improvement followed. The infiltrations became levelled down, and the author felt justified in his conclusions that the drug exercises a decided influence on the resorption of lupus infiltrations, although probably not under all conditions, and possibly it is not to be hoped that entire healing will take place under its administration. It is to be noted that the drug was given in large doses and for a considerable length of time.

### DRESSING OF CONTUSED WOUNDS WITH DECOCTION OF VALERIAN ROOT.

DR. ARRAGON has recently communicated to the Société de Biologie the results of his treatment of contused wounds with the following preparation :

℞ Rad. Valerianæ..... 30 grams.  
Aq..... 1 litre.

Boil for half an hour, strain, and apply over the wound compresses soaked with this decoction. Keep the compresses constantly moist. M. Arragon reports nearly fifty cases in which this treatment was satisfactory. The cure is not more rapid than with ordinary dressings, but the remarkable fact is that the symptom of pain is entirely annihilated. This is probably due to the action of valerianic acid upon the terminal filaments of the nerves.—*Journal de Médecine et de Chirurgie*, Oct., 1885.

### ABORTION OF SMALL-POX.

REIMER who has had a large experience in the treatment of small-pox, strongly recommends as the best means of aborting commencing pocks, the use of Schwimmer's salve, composed as follows :

℞ Acidi Carbolicæ..... grs. 30 to 80  
Ol. Olivæ..... 3 v.  
Cretæ pulv..... ½ i.  
M.

It may be applied on linen to any or all of the affected places and changed twice daily. In not one case in which it was applied was the suppuration well marked, and only seldom were slight scars formed on the nose. The method is not applicable to young children, both on account of the difficulty of retaining the bandages in place, and of the liability to carbolic acid intoxication. Acting on a suggestion of Clavidge, Reimer administered sodium salicylate in 5-10 gr. doses day and night in fourteen cases, and found in every case, even on the second day, a distinct arrest of development of the pustules. They remained flat and quickly dried up from the centre.—*St. Petersburg Med. Woch.*; *Med. Chronicle*, Sept., 1885.

## Items.

**TREATMENT OF PSORIASIS.**—In psoriasis, Dr. Guibout prefers the oil of cade, having it well rubbed in, and ordering soda baths every day or so, this treatment to be continued until the pigmentation due to the disease has disappeared. If, for any reason, he cannot use the oil of cade, he employs a five to fifteen per cent pyrogallic-acid ointment, having it applied twice a day, and directing the patient to take a daily bath.—*Gazette des Hôpitaux*, No. 88, 1885.

**THE PRURITUS OF DIABETES.**—Dr. Blanchet, of Vichy, recommends in the treatment of this distressing complication of diabetes the use of alkaline sitz-baths for sixty minutes at a time, followed by lotions of glycerin. He has had good results from the use of an ointment composed of the oxide of zinc, twenty-five grams; salicylic acid, one gram; and glycerole of starch, twenty-five grams.—*Gazette des Hôpitaux*, September 22, 1885, p. 868.

**DIAGNOSIS OF GONORRHOEA IN THE FEMALE.**—Dr. Martineau claims that a specific may be distinguished from a simple vaginal discharge by the simple expedient of using a piece of litmus paper. In the specific form the reaction is always acid, while in the simple form it is always alkaline. The same test is also of value in cases of rape in deciding whether the person who committed the crime was then suffering from gonorrhœa, as the vaginal discharge proceeding from this cause would be acid.

**MICROCOCCI OF ALOPECIA AREATA.**—At a late meeting of the Society of the German "*Naturforscher und Aerzte*," Professor von Sehlen called attention to the fact of his having made cultures of characteristic micro-organisms taken from a typical case of alopecia areata. He eliminated all sources of doubt arising from a possible mistake of the disease for herpes tonsurans, and maintained that the existence of these cocci is both constant and pathognomonic of the disease.

**TREATMENT OF FRECKLES WITH CARBOLIC ACID.**—Dr. Hal-kin's procedure is as follows: The skin being washed and dried, is put on the stretch with two fingers of the left hand, and a drop of pure carbolic acid is applied exactly over the patch. When it dries the operation is completed. The skin becomes white, and the slight sensation of burning disappears in a few minutes. The thin crust which forms after the cauterization should not be disturbed; it detaches itself spontaneously in eight or ten days, leaving a rosy coloration, which is soon replaced by the normal color of the skin.

**QUININE IN SKIN AFFECTIONS.**—In the *Monatshefte f. Prakt. Derm.* Hager calls attention to the great value of quinine and its derivatives, both externally and internally, in skin affections. Sub-ungual whitlow he has always been able to cure readily in two to three days, by using a water-bath and administering pills of sulphate of cinchonidine in dose of two and a half grains hourly the first day, and less frequently afterward. In a highly inflamed varicose leg with oozing eczema, quinine reduced the inflammation so that the patient could walk within a week, and had no relapse. In facial erysipelas, and in a number of acute local surgical affections, he has been equally successful.—*Med. Chronicle*, Nov., 1885.

71

JOURNAL

OF

CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

MARCH, 1886.

No. 3.

---

**Original Communications.**

---

ON THE LIMITATION OF THE CONTAGIOUS STAGE OF SYPHILIS,  
ESPECIALLY IN ITS RELATIONS TO MARRIAGE.<sup>1</sup>

BY

FESSENDEN N. OTIS, M.D.,

Clinical Professor of Venereal Diseases in the College of Physicians and Surgeons, New York.

IN seeking to establish the limit of the contagious stage of syphilis it is important to appreciate what has up to the present time been determined in regard to the nature of the contagium of syphilis. The microscopical investigation of Burdon Sanderson, Beale, and Chauveau resulted, a quarter of a century ago, in the discovery of the disease germs of variola, vaccinia, the cattle plague, and relapsing fever.

It was then demonstrated that a living germinal cell was the starting-point of those diseases in each case. Beale, besides this, claimed that another germinal cell with properties and powers identical with those of the human white blood-corpuscle was the starting-point in syphilis, and he also claimed that this cell was directly descended from degraded cell elements of human origin. It was represented as varying in size, from that of the normal white corpuscle, in proportion to the degree of its degradation, from 1-3,000th to 1-100,000th of an inch, or even less in diameter.

With nothing in its composition or in its physical proportions to distinguish it from the nuclei or the nucleoli of the normal white blood-corpuscle, hence with nothing but its morbid activity, its increased capacity for proliferation, to distinguish it from the normal cell element, it is not surprising that Beale should have failed to demonstrate his theory

<sup>1</sup> Read at the Annual Meeting of the New York State Medical Society, Feb. 5, 1886.

through microscopic investigations. Alfred von Biesiadecki, of Krakow, however, in 1867 discovered a marked proliferation *in loco* of apparently normal cell elements at the site of the syphilitic inoculation, progressing chiefly, if not solely, in the line of the lymph channel, and accumulating in a characteristic way in the lymphatic glands in connection with them, and he claimed this as an evidence that it was through the lymph channels alone that the syphilitic infection invaded the organism.

Cohn soon afterwards showed also, through extensive microscopic researches, that the papules of the active or so-called secondary stage of syphilis were caused by an accumulation of germinal cells, similar to those demonstrated by Biesiadecki in the initial lesion of syphilis and in the adjacent lymph channels and glands, and that the mucous patches and tubercles and the alopecia of syphilis were caused by a similar localized accumulation of cells, proliferated through the syphilitic influence. Other competent observers confirmed these discoveries, and the investigation was pushed forward, notably by M. Cornil, of Paris, until it was shown that every lesion and manifestation of the active or so-called secondary stage of syphilis was characterized by the same aggregation of the newly-formed cells possessing the contagious property of syphilis, but free from any other distinctive quality except so far as it might result from the greater tendency of new formation to break down into pus, or from the mechanical pressure caused by the accumulation.

The contagious property of these cells, their power to communicate syphilis through contact with an abraded surface in an otherwise healthy organism, required explanation before the degraded white blood-cell or disease germ of Beale could be accepted as the true contagium of syphilis. Rindfleisch, in 1870, called attention to a fact observed by him that the normal germinal cells exert an influence upon one another through contact. He says: "The opinion is inevitable that the embryonal formative cell can only become an epithelial cell when it comes in contact with such; we must believe in a kind of epithelial infection." If, then, infection of cells by other cells is accepted as a physiological process, certainly the power of a degraded white blood-cell to accelerate proliferation in normal cells with which they may come into contact may be accepted; and we then have in the degraded white blood-corpuscle of Beale all the necessary attributes to figure effectively as the true contagium of syphilis.<sup>1</sup>

Through its acceptance as such, I think it can be shown that we have a clue which will lead us to a reasonable explanation of every stage and

<sup>1</sup> This view of the case does not preclude the idea of a possible specific micrococcus which penetrates the germinal cells, may then become the cause of infection in the same manner as the disease germ of Beale, but until this micrococcus is absolutely demonstrated, we may reasonably accept the possibilities in favor of the degraded white blood-cell.



lesion of syphilis—an explanation in full harmony with all known physiological and pathological laws. Through it we are led to the adoption of a course of treatment which, while still in accord with the results of clinical experience, is no longer empirical. On the other hand, for now more than twenty years microscopists all over the world have been diligently searching for the syphilitic entity or virus, but without success, although its alleged discovery has been announced with great publicity and positiveness from time to time. First it was a minute and peculiar vegetable spore (Salisbury), but this, through more extended investigation, was found unessential to the development of syphilis. It has been displayed to continental scientists as a peculiar property (Lorstorfer), and was accepted for a brief period as the veritable contagium of syphilis; but this was soon proved to be but the simple outcome of various forms of cachexia. Then a rod-shaped micrococcus (Klebs) was brought forward, and claimed to be capable of producing lesions resembling those of late syphilis, but this too proved a failure.

More recently, within the past year, it was announced that Dr. Lustgarten, of Vienna, had at last discovered the true virus of syphilis in a characteristic bacillus which he described with great exactness and circumstantiality. Within a few months, however, investigations touching the validity of this discovery were set on foot by M. Cornil, of Paris, when it was soon determined that Lustgarten's discovery must be relegated to the list of previous failures. The bacillus in question, while found frequently associated with syphilitic lesions, was not confined to them, but was found in the secretions about the prepuce, the pudendum, and the anus in persons not syphilitic.

It will thus be seen that the disease germ of Beale is the only one now in the field which demands consideration as the contagium of syphilis, and it will be my effort to-day to point out the important relations in which it may be claimed to stand with the acknowledged mysteries and disputed doctrinal points of syphilis, especially as affording us much needed assistance in studying the limitations of the contagious stage of the disease.

Although not strictly germane to our subject, permit me, in the first place, to call your attention to the important fact that it is through recognition of the proliferation of cell elements, as a characteristic feature of the initial lesion of syphilis, that we are enabled to set at once and finally at rest the long disputed point as to the unity and duality of syphilis. Through this view it is seen that syphilis is a disease essentially of growth, destruction of tissue occurring only as the result of overgrowth, through which the vessels of nutrition of the part are obstructed; while in chancre the process is a destructive one *per se*. Syphilis may, and not infrequently does, go through all its stages in a characteristic man-

ner without a single breach of tissue, while Chancroid is always and only a process of destruction of tissue.

In whatever consists the true contagium of syphilis, one important fact in relation to it is well proven, namely, that it is contained in the substance of the initial lesion or chancre, and the lymph channels and glands in immediate relation thereto, and that, as a rule, for a period of at least eight weeks, it is confined between this point and the general blood current.

It will thus be seen that the doctrine of a mysterious instantaneous syphilitic infection, as still claimed by some authorities, is denied, and that a gradual infection, through physiological channels, alone can be considered possible.

A few words in proof of this position : Inoculation of healthy persons with the blood of a person affected with an initial lesion of syphilis failed to communicate syphilis until after the eighth week from the date of infection. Several well authenticated cases of this sort have come to my knowledge. Twice the inoculation was in my own person. A great amount of evidence on this point is furnished by Diday. In his work on infantile syphilis, Diday says that syphilis, contracted by the mother, after the seventh month of gestation, has never produced the disease in the fœtus. Abernethy had previously claimed the same immunity for the fœtus after the seventh month, but Diday asserted it as a *law* to which there were practically no exceptions. On page 32 of his work on "Infantile Syphilis," Sydenham edition, 1859, he says : "Under similar circumstances, a child born apparently healthy of a woman, who had contracted syphilis in the eighth or ninth month only, might be entrusted to a nurse without fear of communicating the disease to her."

Practically, then, it is thus shown that the disease, being limited to the initial lesion and its immediate vicinity, during the first two months after infection, syphilis may, up to such period, be claimed as a local and not a constitutional disease.

It has been proven and accepted by such authority as Fournier and Cornil, of Paris ; Mireur, of Marseilles ; Van Buren and Keys, and Bumstead and Taylor, of New York ; Hill and Cooper, of London, and others, that the physiological secretions, mucus, milk, tears, sweat, sebum, urine, semen, etc., do not contain the contagium of syphilis.

A consideration of this important fact enables us to eliminate from the mysteries of syphilitic contagion, such cases as those where the father is claimed to have infected the embryo or fœtus, while the mother escaped the disease, and also makes it clear, beyond dispute, that syphilis is never, under any conceivable circumstances, communicated from the father directly to the fœtus, but that, in order to infect the product of conception before birth, the mother must first be infected ; the semen having been

proven not to contain the contagium of syphilis, settles this much-discussed question, inasmuch as, through the semen alone, has the father any possible access to the ovum or the fœtus.

It will also be seen that, if the physiological secretions, which do not contain germinal cells, are free from the contagium of syphilis, this constitutes a strong argument in favor of the nature of the contagium of syphilis, as claimed; and further, if contact of a degraded germinal cell, is essential to the production of syphilis, and the disease is conveyed to the embryo or fœtus, only through the blood of the mother, there is no longer, strictly speaking, any hereditary transmission of syphilis. In order to the acquirement of syphilis, an organism free from that disease is essential. The infecting cell of syphilis, must first be brought in contact with otherwise healthy cell material. "No mysterious hereditary influence is necessary, nor can be admitted. If the disease germ of syphilis, by contact with external parts, or through its amœboid power traversing tissue, reaches healthy cell material, whether in the adult, the infant, or the embryo, then the syphilitic influence is *directly transmitted*, and its development must be governed by the same laws that characterize its progress in the known behavior of the disease in the adult, modified, to a greater or less extent, by the age and degree of stability of the tissues involved. It is true that various adynamic conditions in fœtal and infantile life, result from pre-existing disease in the generative organs of parents who have been subjects of syphilis; but that any syphilitic disease, proven to be such by its power to transmit syphilis, has been communicated to healthy persons, after the action or so-called secondary stage of the disease has passed, there is no well-authenticated evidence to prove."

I am quite aware that this position will at first be received with surprise, but it is the logical sequence of the acceptance of the degraded human germinal cell as the true contagium of syphilis, and it can, I believe, be shown to be in the fullest accord with all well authenticated facts in regard to hereditary syphilis.

These views were originally published by me, in a series of class-room lessons, in 1879, and again in my volume on the Physiological Pathology of Syphilis, in 1881, and elaborated more fully in an article on the syphilis of infants and hereditary syphilis, in 1884. It is worthy of remark that Mr. Jonathan Hutchinson, of London, a leading authority on syphilis in Great Britain, has arrived at conclusions identical with my own, in regard to the nature of the so-called Hereditary Syphilis. Thus, in his "Pedigree of Disease," published in London, 1884, page 90, he says: "A child then, I assert, inherits syphilis in precisely the same sense and in precisely the same manner as it may inherit small-pox. It inherits, not *the diathesis*, but *the disease*. The reason why the inheritance

of small-pox is rare, while that of syphilis unfortunately is common, is simply that the period during which the virus is extant, in the blood, is very different in the two cases. The conspicuous facts, then, in reference to the syphilis of infants, afford no proof that the diathesis of syphilis, any more than those of the other exanthemata, is capable of transmission." Mr. Hutchinson further says: "My argument, if I have made it plain, has pointed to the conclusion, that, no *minified* transmission of syphilis is possible, and that the child gets, either nothing at all, or the germs of the disease, and that in the latter case they will, subject to the laws of idiosyncrasy, develop equally in all cases."

Having thus indicated the limitation of the contagious element of syphilis in the matter and mode of infection, we have now reached a point where we may, I think, proceed to the consideration of the probable, or possible, limit of the contagious stage of syphilis, in point of time. A very general impression prevails, both in and out of the profession, that syphilis is capable of being communicated to healthy persons, by a person, once the subject of the disease, either by contact or by heredity, throughout the lifetime of the individual. It is a common belief that, when, after years of freedom from any evidence of the disease, any lesion is recognized as due to a former syphilis, it is an evidence of a poison still remaining in the blood of the individual, and that it may be transmitted to a healthy person by contact or by heredity. It has, however, now come to be understood, practically, that when the accumulations of cell material, which have caused the lesions of the secondary stage, and the enlargement of the lymphatic glands at various points, have been eliminated, the disease is, as a rule, no longer contagious, and persons, the subjects of syphilis, who have, by systematic and thorough treatment, been brought to this condition, are said to be cured of syphilis. The time during which the treatment is recommended, by authors, to be continued, is pretty uniformly fixed at about three years. If then, the patient has been free from all signs of syphilis for one year, he is pronounced cured, and he is permitted to marry.

Fournier says: "The truth is that, with some very rare exceptions, syphilis constitutes only a temporary bar to marriage." Bumstead and Taylor say: (5th Edition, page 91) "It may be stated in broad terms that no syphilitic father should procreate children until two years after infection, during which he should sedulously follow a systematic course of treatment." Keyes (Venereal Diseases, Wood & Co., 1880) says: "After the virulence of the disease has been exhausted, a man may marry, and should marry." Again, page 78, *ibid.*, "In a general way it it may be safely said that a man should not marry until at least three good years lie between him and his chancre, and at least one year has elapsed since the last symptom which can be ascribed to syphilis." Hill



and Cooper (London, 1881): "Under any circumstances, the shortest period between infection and marriage should be three years. . . . Under no circumstances should a person with obvious signs of syphilitic disease marry, however long a time has elapsed since his infection, for, though communication is rare when several years (four or five) have elapsed, *it may still take place after as many as ten or even more years, even when the form of disease is of the character commonly called tertiary.*"

It will thus be seen that authors are not quite harmonious in regard to the safety of marriage after syphilis, although all are agreed that no marriage should be permitted until a year after the disappearance of any lesion which could be attributed to syphilis. All, however, are agreed, that the communication of syphilis, after the third year of its existence is rare. It has, however, been determined, by careful clinical observation, that the contagious element of syphilis, is, as a rule, eliminated within a period varying from perhaps two to four years, and that all the manifestations of disease beyond this time, and apparently due to syphilis, called tertiary lesions, are not entitled to be considered, strictly speaking, as syphilitic. Mr. Hutchinson says of them: "What are called tertiary symptoms do not constitute a necessary stage of syphilis, and are to be regarded in the light of sequelæ." This statement is corroborated by the fact, now well determined, that the secretions of all such lesions are innocuous; and that neither they, nor the tissues, nor the blood of patients bearing such lesion contain a contagious element. Without the *contagium* there can be no syphilis. Ricord claims that tertiary lesions are not inoculable and cannot be transmitted by hereditary descent. Bumstead and Taylor (4th Edition) say, after reviewing this matter, "Hence we consider the blood and the secretions in tertiary syphilis innocuous." Diday performed inoculations with the blood of persons in the tertiary stage of syphilis, with a negative result.

If time permitted, I think it could be satisfactorily proven to you that the tertiary lesions of syphilis, are invariably due to obstructions of lymphatic spaces and channels, the result of simple pathological changes occurring during the active or contagious stage of syphilis. I will simply say that it has been determined, through microscopic examination, that *all* the lesions of tertiary syphilis are characterized by an accumulation of so-called gummy material, and that this gummy material has been found not to differ, in any essential respect, from normal germinal material, and that the damage associated with it, may, in every case, be fully accounted for, by the mechanical influence of its presence. It is to the occasional occurrence of tertiary lesions, in persons who have passed through the active stage of syphilis, that a persistence of the syphilitic diathesis, with all its power of communicating syphilis, for an indefinite

period, even possibly through the lifetime of a patient, is claimed. If, therefore, it can be absolutely proven, that the active or contagious stage of syphilis, does not last indefinitely, and that the lesions of the tertiary stage and the blood, during this period, are also free from the contagium, we may then hope to reach some definite limitation of the contagious stage of syphilis in all cases.

The acceptance of the degraded human germinal cell, as the true contagium of syphilis, and its logical sequences, as determined through our knowledge of minute physiology and pathology, will lead toward, if not definitely to, such a result. But it is to competent and well-authenticated clinical records, that we must now look for the solution of the important question at issue.

(To be continued.)

---

## ON THE DIAGNOSIS OF SMALL-POX.<sup>1</sup>

BY

PRINCE A. MORROW, A.M., M.D.

**A** PAPER upon so trite a subject as the "Diagnosis of Small-pox," may appear, in the estimation of many members of this Society, to demand an apology for its presentation. The diagnosis of a disease which is so characteristic in its mode of invasion, so regular in the order of its evolution, and so definite in the duration of the morbid process, would seem to offer few difficulties. But while the features of a typical case of small-pox are so striking and distinctive as to render it easy of recognition, yet the atypical, modified forms present so many points of similarity with other eruptive diseases that their early differential diagnosis may embarrass even the most practised physician.

Professional attention has been recently directed to the importance of this subject by the marked increase in the number of small-pox cases in this city within the past few months, and the apprehensions which have been excited of a threatened epidemic outbreak of the disease. The interest of the profession has also been awakened to the responsibility incurred in making a diagnosis of small-pox, by the fact that a reputable physician of this city has been mulcted in damages for an alleged mistake of this nature. It is not my purpose to comment upon the unjust and iniquitous character of the decision in this case. It involves a medico-legal question of great practical interest and moment to every member of the profession, and unfortunately, it will stand as a precedent unless it be reversed. The members of this Society have shown

<sup>1</sup> Read before the Medical Society of the County of New York, Jan. 25, 1886.

their recognition of this fact by an organized effort to have the case appealed.

Apart, however, from these accidental incentives to a quickened interest in this subject, the importance of the early diagnosis of small-pox cannot be over-estimated. In the case of most diseases, a correct diagnosis is chiefly valuable as furnishing indications for treatment, but in the case of a contagious disease it has a more important bearing upon the interests of others. We recognize a small-pox patient as a source of danger to all with whom he may come in contact; a centre of contagion to all who surround him. The recognition at the earliest possible moment of this source of danger and the prompt isolation of the patient, constitute the most efficient means at our command of limiting or circumscribing the spread of the disease.

As an example of the remarkable radiating power of the contagion, it may be stated that, in a former epidemic in this city, forty cases of small-pox in a public institution were directly traced to contact with a single attendant, the nature of whose disease was not recognized by the attending physician.

While it is important, in the interests of the public health, that the disease should be promptly recognized and the patient isolated, it is equally important, both in the interest of the patient and for the credit of the physician, that a mistake should not be made in the opposite direction and the patient sent to the hospital and exposed to the almost certainty of contagion from contact with small-pox patients. The laity are little tolerant of such mistakes and usually attribute them to ignorance, carelessness, or undue haste on the part of the physician.

Practically, however, we find that such mistakes are often made, even by the most careful and experienced physicians. The records of all small-pox hospitals are prolific in statistics of this nature. Marsden in his classic paper on small-pox (Reynolds' "System of Medicine," page 445) says, "Upwards of twenty diseases have been mistaken within the past few years, in the early stage of the illness, for small-pox and the patients have been sent, as having small-pox, to the London Small-pox Hospital."

Neumann, who had charge of the Vienna Small-pox Hospital in the epidemic of 1872-73, reports that thirty-five patients with measles, scarlatina, erythema, etc., were erroneously admitted as having small-pox.

The following statistics, taken from the records of the Small-pox Hospital of this City, from 1880-1885 inclusive, were kindly furnished me by Dr. F. W. Chapin. During this period, over 2,500 cases of small-pox were admitted into the hospital. Thirty-one cases wrongly diagnosed as small-pox are classified as follows: Typhus, 13; measles, 9; syphilis, 3; acute eczema, 1; variella, 1; psoriasis, 1; aene, 1; purpura hemor-

rhagica, 1; malaria, 1;—making a total of 31 cases. On the other hand, eleven cases of small-pox wrongly diagnosed are thus classified: Typhus, 8; typhoid, 1; scarlet fever, 1; measles, 1. A total of 42 instances of mistakes as regards small-pox. In addition to these there was a much larger number of wrongly diagnosed cases which were received at the Reception Hospital in East 16th street and not transferred to the Island Hospital.

An examination of the record of the "Reports of Contagious Diseases submitted to the Board of Health of this City for the past twelve weeks ending January 16" discloses the fact that seventy-two cases of small-pox had come under the observation of the Health Board within this period. In addition to these cases of undoubted small-pox, thirty-eight cases were reported as such, which, upon investigation, were found not to be small-pox. An analysis of these 38 cases shows that the diseases mistaken for small-pox were represented as follows: Varicella, 17; syphilis, 5; measles, 3; lichen tropicus, 1; lichen, 4; vaccinia, 1; herpes, 1; pemphigus, 1; miliary fever, 1; sudamina, 1; erythema, 1; urticaria, 1. I have included in this list only such cases as were reported in the name of the attending physician, and have excluded therefrom quite a large number of cases which were reported through the telephone, by the police and other agencies. The large number of mistakes in diagnosis disclosed by this exhibit, it may be remarked, is the more significant considering the comparatively few cases of small-pox in the city. In the presence of an epidemic outbreak of the disease, when physicians are more keenly alive to the possible variolous nature of every doubtful eruptive disease, it may be reasonably inferred that a proportionately larger number of mistakes would occur. Incidentally it may be mentioned that at least two of the mistakes were made by physicians who presumably possess more than ordinary skill in the diagnosis of eruptive diseases, as both have been prominently identified with the teaching of skin diseases in medical colleges in this city.

These facts are not brought forward as an arraignment of the medical profession for carelessness or incompetency; they are not to be interpreted as an impeachment of the clinical judgment or diagnostic skill of the physicians making the reports. They simply illustrate the fact that in a certain proportion of cases of eruptive disease it is often impossible for the physician to pronounce positively upon the nature of the disease within the first twenty-four hours. However strongly the clinical signs may point in favor of the variolous character of the eruptive accidents, there are so many sources of error possible that the physician should suspend judgment until time clears up the diagnosis. Taken in connection with the recent interpretation of the law in the Purdy case, they emphasize the importance of the movement now on foot to



memorialize the Legislature to pass an act which shall secure to the physician exemption from all damages for compliance with the regulations of the Board of Health.

As before intimated, no other disease is characterized by more distinctive symptoms or is more readily recognized than a typical case of small-pox. The series of changes which the eruption undergoes in its development and decline are too familiar to be here described. They may be briefly referred to, however, in order to bring into relief the deviations from the ordinary evolution of the disease.

Small-pox ordinarily begins with a chill, succeeded by a fever with headache, severe lumbar pains, nausea, sometimes vomiting and other signs of constitutional disturbance. These symptoms subside with the appearance of a rash on the third day, in the shape of small distinct papules, hard and shotty to the feel, first appearing on the forehead, face, and back of wrists, successively invading the neck, trunk, arms, and lower extremities. On the fifth day, the papules are converted into vesicles which become depressed in the centre and surrounded by an areola. On the eighth or ninth day, the vesicles are transformed into pustules which, after the eleventh day, burst, discharge their contents and form scabs, which fall off, leaving pigmented cicatrices, the entire process being completed in from seventeen to twenty days. This series of symptoms and the regular order of their succession make up a clinical picture which is imitated by no other disease. While many of the symptoms are common to other eruptive fevers, yet the acute lumbar pain and the subsidence of the fever upon the appearance of the eruption are pathognomonic of small-pox. The same may be said of the eruptive features. The anatomical form of the lesions is not peculiar to small-pox, yet the pock occurs in other diseases rather as an accidental formation than a typical lesion; its mode and rate of development are altogether different.

The diagnosis of small-pox is usually difficult in proportion to the duration of the attack. In the early stage, when the premonitory symptoms are doubtful and the character of the eruptive accidents uncertain, the simple element of time resolves all doubt. A papular eruption, for example, which remains unchanged longer than two days, does not indicate small-pox, since the transitional stage of the small-pox papule does not surpass that period. However important the chronological element may be as a differential factor, practically we cannot always apply the test of time, since we are compelled to report an opinion within twenty-four hours after first seeing the patient, and this enforced precipitancy in making a diagnosis is the explanation of many mistakes which would not be possible at a later period, when the disease is more advanced in its evolution.

In the early eruptive stage, the premonitory symptoms, especially

when conjoined with a history of known exposure, are much more important from a diagnostic point of view than the eruption itself. The initial exanthem, especially when hemorrhagic, is, of course, pathognomonic, but it occurs with such a varying degree of frequency in different epidemics that its inconstancy deprives it of value as a diagnostic element.

It is, however, the modified forms of small-pox, and the cases characterized by the production of macular, measly, and hemorrhagic rashes, that occasion the most difficulties of diagnosis. Undoubtedly the chief element of confusion has been introduced by the practice of vaccination. Vaccination *denaturalizes* small-pox: it deranges the regular order of its evolution and effaces its most distinctive features. This modification varies in degree in different individuals, according to the efficiency of the vaccination and the proximity of its performance.

Varioloid may have nothing constant, nothing definite, either in its constitutional accidents, the character of the eruption, or the duration of the morbid process. The premonitories may be as severe and protracted as in true variola, or they may be slight and of but a single day's duration. The eruption, instead of beginning upon the face, may make its first appearance upon the chest, back, or extremities, it may be sparsely scattered or thickly disseminated. Some of the lesions may abort at the papular stage or the vesicle may represent the acme of development. There may thus be present at the same time abortive papules, dried up vesicles, and advanced pustules. Umbilicated vesicles which constitute the specific sign of small-pox may be entirely wanting. Desiccation may begin as early as the fifth day. It is very rare indeed that the eruption passes through the entire cycle of evolution typified by the true variolous process.

Notwithstanding the benign character of varioloid, it possesses the same contagious activity as true variola, and, from a prophylactic point of view, its early recognition and the prompt isolation of the patient is quite as important. A case of peripatetic varioloid may be a more efficient agent in spreading the contagion than a case of confluent small-pox.

*Measles.*—Passing now to the consideration of the differential diagnosis of the diseases most commonly mistaken for small-pox, it may be said that, in point of frequency, measles occupies the front rank. While the period of invasion is a little longer in measles, the initial eruption of some forms of small-pox is oftentimes indistinguishable from that of measles, especially when of the papular variety, and it does not appear so surprising that these diseases were so long regarded as identical.

In measles there is often a coincident development of the eruption upon the back and face, while in small-pox it first appears upon the face. The papules of measles are larger, softer, and of a more vivid hue, con-

trasting with the pale color and hard shotty character of the small-pox papules. The former give to the hand passed over the surface a smooth velvety feel, while the latter communicate a rough, harsh sensation. It is, of course, only at the onset of the eruption that such a confusion is possible; in the course of twenty-four to thirty-six hours the papules of measles become more macular, while the papules of small-pox manifest evidences of a vesicular transformation. Independent of the eruption, the most important differential signs are the absence of lumbar pain during the period of invasion of measles, the maximal development of temperature during the height of the eruption, and the coryza, lachrymation, and other mucous membrane symptoms peculiar to this disease.

Measles may also be confounded with a form of hemorrhagic small-pox, in which the measly eruption is succeeded by petechiæ which may constitute the only cutaneous expression of the disease, and the patient often dies of hemorrhagic small-pox without a trace of a vesicle being present or before any unequivocal signs of small-pox are manifest.

*Varicella.*—In the record of thirty-eight cases wrongly reported to the Board of Health as small-pox, there were seventeen cases of variella. This relatively large proportion may be explained by the fact of the unusual prevalence of variella in this city at the present time. A small contingent may have been reported by physicians who believe in the substantial identity of the two diseases—an opinion which was formerly generally held, and is still entertained by some authorities. Considering the close resemblance of variella to modified variola in the mode of its development and the anatomical form of its lesions, it is not surprising that the two diseases should sometimes be confounded. This resemblance is rendered more striking in the exceptional cases in which variella is attended with a high degree of constitutional disturbance, with distinctly umbilicated vesicles which are followed by sloughing of the skin and permanent cicatrices. Ordinarily, however, there is slight systemic disturbance or none at all. The rise of temperature follows, rather than precedes, the eruption which is often the first symptom that marks the disease. The eruption is most characteristically developed upon the back, but may be distributed over the entire body. The vesicles are superficial; they rise from a hyperæmic spot, rapidly mature, and attain their maximum development in one or two days; they are soft, globular in shape, rarely umbilicated, and unicellular in structure; their contents may be evacuated by a single puncture. The individual lesions pass through their successive changes in from five to ten days. An important differential feature is that the eruption comes out in successive crops, so that we may have the eruption in different stages of development at the same time. Another diagnostic feature is that variella is essentially a disease of childhood; some authorities maintaining that the occurrence of a varicella-like

eruption in an adult would necessarily exclude the diagnosis of chicken-pox. Clinical experience would seem to prove, however, the susceptibility of adults, though in the slightest degree, to varicella.

*Scarlatina.*—The resemblance of the prodromic rash of small-pox to scarlatina is sometimes most striking. The absence of sore throat and the typical tongue of scarlatina, taken in conjunction with the symptoms of invasion, are important diagnostic points. The appearance of a papular eruption on the third day would resolve all doubt. In hemorrhagic small-pox the intense congestion and the dark-red color which sometimes precedes the hemorrhagic exanthem may simulate a scarlatinal eruption.

*Typhus Fever.*—In the statistics of the Small-Pox Hospital it will be remembered that thirteen cases of typhus fever were diagnosed as small-pox, and eight cases of small-pox were mistaken for typhus. It is, of course, only in one of the hemorrhagic forms of small-pox that such a mistake is liable to occur. The purpuric eruption of small-pox occurs at an early period and the patient rarely lives to the seventh day, at which time the eruption of typhus appears. In variola hemorrhagica, the purpuric spots are larger and are attended with hemorrhages from the mucous membranes and hemorrhages into the conjunctivæ. In typhus fever, there is active delirium and other mental disturbances, while in hemorrhagic small-pox the mind is perfectly clear. The exanthem of spotted fever (cerebro-spinal meningitis) may also be mistaken for the petechial eruption of small-pox.

*Purpura Hemorrhagica*, as well as the cutaneous hemorrhages of purpura simplex and peliosis rheumatica, have been mistaken for petechial small-pox. In purpura, the eruption first develops upon the lower extremities, and rarely extends to the trunk and upper extremities. The history of the invasion, the sudden advent of the eruption, and the absence of subjective symptoms are important differential points.

*Syphilis.*—The similitude of syphilis to variola, it may be inferred, was recognized by the older authorities in giving to the latter the name of "small"-pox, and the term variola-form syphilide, which is still employed by modern writers on venereal, would indicate the identity of certain forms of dermato-syphilis with the characteristic lesions of small-pox. There is not only identity of anatomical form, but also of development through the stages of papule, vesicle, and pustule. The similitude is heightened by the fact that in some rare cases syphilitic lesions may present well-marked umbilication. The differential points are the history of the case, the more sluggish development of the syphilitic lesions, the grouping of the eruption, the absence of subjective symptoms, and the probable presence of other evidences of syphilis. It is very rare indeed that a disease so polymorphic as syphilis does not present a number of dissimilar eruptive elements at the same time.



*Lichen*.—*Papular Eczema* may be mistaken for the commencing eruption of small-pox. Five cases of lichen are recorded in my list. Marsden states that “febrile lichen is more like small-pox, modified small-pox especially, than any other form of disease is, non-variolaous.” It must be observed, however, that the disease he alludes to as lichen febrilis or lichen agrius is classified in our nomenclature as a form of eczema. It is exceedingly rare that an outbreak of eczema is preceded with severe febrile symptoms. The systemic disturbance, if at all marked, is consecutive to the general diffusion of the eruption over extensive surfaces. Eczema is further differentiated by the more intensely red, itchy character of the eruption, the size and color of the papules, its irregular distribution, and especially by the non-involvement of the mucous membranes.

*Sudamina*.—It would hardly seem probable that this eruption should be mistaken for small-pox, yet two cases, one of sudamina and one of miliary fever, were so reported. The dewdrop-like lesions of sudamina, their superficial character, and greater abundance upon covered parts would serve to differentiate the eruptions. Moreover, the vesicles of sudamina attain their complete development in a few hours, and remain unchanged throughout their course. Dr. Jacobi reports (*Med. Record*, 1882, p. 443) the case of a woman in Bellevue Hospital, in which he was unable to make a positive diagnosis during the first four days of the disease. The body was profusely covered with a sudamina-like eruption, the face being free, on fourth day her face became covered with an eruption, not characteristic, but sufficient to establish the diagnosis of variola. Dr. Janeway stated that similar doubtful cases are not rare.

*Pemphigus and Herpes* are recorded as having been mistaken for small-pox. In pemphigus, the larger size of the bullæ, their development upon an erythematous base, their hemispherical or globular form, and the rapidity of their evolution, would serve to distinguish them. The contents of the bullæ quickly become turbid or they readily burst, leaving excoriated surfaces; moreover, they come out in successive crops. Catarrhal herpes is a more or less constant attendant upon many febrile affections. The vesicles are always few in number, which, with their clustered character, their tendency to develop at the junction of the skin and mucous membranes, and the restriction of the eruption to these localities should serve at once to differentiate it.

*Erythema and Urticaria*.—It is only the papular forms of these diseases in which the eruptive element has any resemblance to that of small-pox. An attention to the invasive symptoms, the absence of fever, the localization, and other characters of the eruption, will serve to eliminate small-pox.

*Acne* has been mistaken for small-pox. In acne there is an entire absence of constitutional derangement, with no subjective symptoms.

The eruption is chronic in its course and limited to certain localities, papules and pustules are usually present at the same time, interspersed with comedones. The element of age is also a differential factor, as the development of acne is ordinarily limited to the period of early adolescence. The lesions are usually conical, and suppuration ordinarily occurs at the summit and not in the totality of the pustule. In the so-called acne varioliformis, or acne atrophica, the eruption is almost always confined to the forehead and margins of the hairy scalp. An artificial acne produced by the ingestion or external application of certain drugs has been mistaken for small-pox. Two cases of iodic acne recently came under my observation which had been diagnosed as small-pox and the patients sent to the small-pox hospital, but were thence transferred to the skin ward of Charity Hospital.

In concluding these hasty and imperfect observations upon this very important subject, I may refer briefly to the evidence of characteristic marks of vaccination as influencing diagnosis. In the case of a doubtful eruption, some physicians would be inclined to exclude variola if there were present marks of a perfect vaccination. But clinical experience proves very conclusively that vaccination, no matter how efficiently and recently performed, does not prevent small-pox. I have already referred to the marked modification impressed upon the disease by vaccination. In some cases, however, it does not materially mitigate the severity of the disease. Kaposi states ("Pathologic und Therapie der Hautkrankheiten," 1880) that vaccination affords no protection against hemorrhagic small-pox. "Purpura variolosa occurs as frequently in the vaccinated and unvaccinated and those who have passed through an attack of small-pox." In this connection it is well to remember that, exceptionally, a mild, modified form of small-pox may occur in persons who have never been vaccinated. The absence of all marks of vaccination, no matter how mild the symptoms, does not then necessarily exclude variola. On the other hand, an attack of small-pox does not protect against successful vaccination. Judging from a recent editorial in the *Medical Record*, there seems to be a lack of clear views upon this point. In the Purdy case, the argument upon which the prosecution seemed to place most reliance in proving the non-variolous character of the plaintiff's eruption, was the fact that she was successfully vaccinated three days after her admission to the hospital. It may be affirmed very positively that an attack of small-pox does not necessarily extinguish the susceptibility to vaccination. Jenner recognized this fact, for he states ("Facts and Observations Relating to the Variola Vaccinæ or Cow-Pox," London, 1880) that "although the susceptibility to the virus of the cow-pox is for the most part lost in those who have had the small-pox, yet in some constitutions it is only partially destroyed, and in others it does not appear to be in the least

diminished." The statistics upon this point, cited by Mr. Seaton (Reynolds' System of Medicine) show that of 1,000 soldiers in the British army who had marks of previous small-pox, vaccination gave a perfect result in 450; of 1,000 men who bore good marks of previous vaccination, the result was perfect in 484; of 1,000 who bore no marks of previous vaccination or small-pox, only 326 were successfully vaccinated. In the *Medical Record* for 1881 are reported a very large number of cases in which vaccination was perfectly successful in those who had had small-pox. To allude to only one report (p. 475), 106 men in a factory were vaccinated, 7 of whom had had small-pox, the result was perfect in 6; of 2 who had had varioloid, 1 was successfully vaccinated.

The limited experience upon this point no doubt arises from the fact that vaccination is rarely performed after the patient has passed through an attack of small-pox, since the operation cannot be urged either in the interests of science or for the practical advantage of the patient.

Whether susceptibility to vaccination exists immediately after an attack of small-pox, or whether it is temporarily extinguished and regained only after the lapse of a certain time, are points which have not been definitely determined.

66 WEST 40TH STREET.

## A CASE OF IODIC PURPURA.

BY

ETIENNE C. VIDAL, M.D.,

Attending Surgeon to New York Dispensary for Skin Diseases.

C. R., 50 years old, consulted me for a debilitated condition of the system, so pronounced in character that it was with the greatest difficulty that he could make the least exertion, this latter always being followed by complete exhaustion. The patient had been under treatment before consulting me, but had obtained no relief. I found him affected with a serious case of cardiac hypertrophy. But this did not account for the debility from which he chiefly suffered. Suspecting that it depended upon some remote cause, I submitted him to close questioning, and obtained an avowal that some twenty years before he had had syphilis, for which he had undergone only a few months' treatment. I ordered him pot. iod. gr. xv., three times daily. Under this, after a week's duration, there was an evident amelioration of the symptoms. The remedy was continued. About three weeks later I was called to see the patient for a dropsical effusion affecting the lower extremities as high as the knee, and the feet. I should state, in passing, that he had had a pityriasis versicolor, involving the neck, chest, back, and arms. It had

existed during the same period mentioned above, and was as evident when I saw him, the patient stated, as it had ever been, but as it never disturbed him he had done nothing for it. Upon examining the inferior members, I discovered a bright red, macular eruption, ranging from the size of a pin-head to that of a split pea, persisting under finger pressure. The dorsal surface of the feet was especially affected. The patient complained at the same time of severe pain in the thighs and top of the feet. The body at the same time offered a number of papules of an acne character. I discontinued the pot. iod., and the purpuric eruption gradually faded away. Believing that it was a case of iodic purpura, I again ordered the medicine in the same dose, his general condition having improved under it, and a week later was a second time confronted with a similar eruption. After discontinuing the iodide to resume it the second time, the purpura appeared for the third time. I now lost sight of my patient, but I am of the opinion that under the same treatment the eruption would have been repeated indefinitely. The patient's health at no time offered any other evidence of the toxic effect of the drug, but, on the contrary, improved so that the man could attend to his business, and ascend long flights of stairs without feeling other inconvenience than increased heart pulsation.

---

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

160TH REGULAR MEETING, JANUARY 26, 1886.

DR. W. T. ALEXANDER, *President*.

DR. JACKSON presented a case of

#### ROSACEA HYPERTROPHICA.

Mr. B., U. S., æt. 51; Janitor. Twenty years ago the patient had an eruption which was pronounced eczema. Denies all venereal diseases. Has been a hard drinker. Suffers frequently with headaches. Has dyspepsia. His tongue is coated white. His bowels are regular.

The patient was first seen September 1, 1885. He came to the hospital on account of his nose which was red, nodular, and very much enlarged. He stated that he had had this trouble with his nose for six months. The left side of the nose was a little larger than the right. There were six or eight superficial, generally oval ulcers upon his nose, especially on the right side. These were partly covered by a thick yellowish-brown crust. On the left side of the nose, on the lower part of ala, was a patulous, small opening which led down into a deep, though narrow pocket. Into this a probe was passed to the depth of one-half inch. There was no disease of the inside of the nose. There were two small, irregular



scaly patches upon the palmar surface of the third finger of the right hand. He was treated by multiple scarifications, with local hot-water bathing at night, followed by white precipitate ointment; and internally by tincture of nux vomica. He was irregular in attendance, but nevertheless steadily improved. On November 3, he was given "mixed treatment," which he took for one week. He did not present himself again till December 29, when he was much better, the nose being smaller, and the redness reduced all but on the tip. Many dilated blood-vessels were found on the nose and cicatrices from the ulcers. He said that up to ten days before this, his nose looked finely, but then began to grow worse.

In presenting the case, Dr. Jackson asked the opinion of the members as to whether it were a simple breaking down of the tissues or if syphilis were superadded.

DR. TAYLOR had seen a similar breaking down of the tissues in those affected with albuminuria, hard drinkers, or those who had cardiac disease. He believed the present lesion to be due to a disintegration or necrosis of the tissues. Vascular changes take place in albuminuria, and in this case we have changes due to inflammation superadded.

DR. BRONSON thought that in this patient, the depressed cicatrices occurring in groups, especially on the right side of the nose, suggested the existence of syphilis in addition to the inflammatory process. He did not know how the condition could be produced otherwise.

DR. STURGIS believed the case to be one of rosacea and that syphilis was not present.

DR. SHERWELL said that when the tissues were once degraded, they would go on to necrosis. He had seen cases where syphilis was added to rosacea.

DR. FOX showed a case of

#### PAPILLOMA OF THE FOREARM.

Four or five years ago, the child's mother noticed a dark mark which appeared over the ball of the left thumb, and which gradually spread. Now there is a warty condition of the ball of the thumb; the lesion extending on the flexor surface of the forearm, forming an irregular patch about an inch and a half or two inches broad. A short time ago, a dark line made its appearance on the inner side of the arm. The lesion is of a dusky red and considerably elevated above the surrounding healthy tissue; it apparently follows the course of the nerve.

DR. STURGIS said that the lesion looked very much like a neurosis.

DR. MORROW had seen cases like this with a similar distribution, and in all of them there was a history of some antecedent injury. He would suspect that there had been some injury to the nerve supplying the parts, the seat of the eruption, which had escaped the child's and mother's notice.

DR. MORROW then exhibited a case of

#### KERATOSIS FOLLICULARIS,

an account of which will be published in a subsequent number.

DR. TAYLOR thought that it was rather premature to give a name to the lesion until the contents of the projecting spines had been examined microscopically.

DR. PIFFARD would take exception to the name given. He considered the lesion to be a sebaceous disease or an affection of the corneal layer.

DR. ALLEN thought that the matter expressed from the diseased portions of the skin was a mixture of epithelium and sebum.

DR. BRONSON believed that keratosis pilaris was a proper name. He considered it to be a disease of the sebaceous follicles with prolonged comedones, and that it was the same disease with which the "bristly" boy was affected. The question if syphilis were present was an interesting one, and also whether the same causes

which produced the diseased condition of the tongue also produced the lesion on the body.

DR. FOX considered the case to be one of keratosis pilaris. The "hedge hog" man and "bristly boy" were examples of congenital disease.

DR. STURGIS believed the lesion on the body to be a keratosis and that on the tongue syphilis. The kerato-iritis was decidedly syphilis.

DR. BULKLEY thought the lesion was a degenerative disease of the sebaceous glands, and that keratosis pilaris was an appropriate name. The horny matter is produced by a hardening of the sebaceous glands.

DR. ROBINSON said that it was useless to discuss the question of a name for the disease, when the pathological conditions present were not known.

DR. MORROW had not examined the spinous projections microscopically, but he had otherwise examined them carefully. They seemed to be drier and harder than comedones, as if the transformation into oily matter had not been completed. He did not see what possible influence syphilis could have on the production of the disease because the chancre dates back only a year, and the lesions on the skin and tongue have been present at least five years. The patient is a sailor and has had to abandon his occupation because he gets worse when at sea and improves when on land.

DR. FOX then showed a case of

#### GENERAL ALOPECIA FOLLOWING KERATOSIS.

The patient, a man about 35 years old, has a general alopecia of the head and body following keratosis pilaris. The hair all over the body and scalp has fallen out, commencing on the scalp, where it fell out in patches. The patient has had syphilis, and the question arose whether the alopecia was at all due to the presence of that disease.

DR. BULKLEY presented a case of

#### DERMATITIS HERPETIFORMIS.

DR. SHERWELL afterward presented a case of

#### NON-VENEREAL SYPHILIS.

Miss J. W., æt 20. Was first seen Dec. 24. At that time she had a sore on the lower lip, with an indurated base, which had been present about one

month. The glands at the angle of the jaw were much enlarged and indurated. A fading primary erythematous eruption was also found. The case was shown on account of the relative infrequency of primary sores occurring in this region,



with such a clear subjective and objective history. The exposure to the contagion occurred about the last week in October, 1885.

DR. PIFFARD presented photographs of

A CASE OF KELOID HAVING SEVERAL POINTS OF INTEREST.

The patient was a female mulatto, aged 35 years, and a native of South Carolina.

The disease had first made its appearance about ten years ago, as various-sized elevations of the skin in the region of the neck and shoulders.

Later on, the lesions became generalized over the whole body, and around the neck took on a peculiar form, encircling the throat in a double coil. The patient had been insane a number of times and had thought this lesion about the throat to be a snake.

The interest of the case rests in the fact that, while new lesions have kept appearing from time to time, many of the old ones have spontaneously disappeared, by a process of involution or retrogressive metamorphosis. The site of each lesion which has thus disappeared is marked by a pigmented spot or stain.

Dr. Piffard called attention to the tendency to fibrous hyperplasia in the mulatto race, as evidenced by the great frequency with which keloid is met with among them and the great tendency they show to uterine fibroids.

DR. PIFFARD also described an apparatus by means of which

PHOTOGRAPHY WAS MADE EASY.

It consisted of a camera with a sufficient number of plates to take twenty-four photographs. The negatives were taken on paper instead of glass, and a paper prepared in bromide of silver was used for printing the photographs. The bromide of silver produced a clearer and better photograph.

DR. TAYLOR then read a paper on

"HYDROA BULLEUX AND KINDRED AFFECTIONS,"

which will appear in the April number.

## Selections.

### SOME MOOT POINTS IN THE NATURAL HISTORY OF SYPHILIS.

*Mutual Relations of the Different Forms of Primary Venereal Sores.*

I HAVE long thought that, if the question in debate could be once clearly stated, the duality or unicity of venereal poisons would soon cease to be a moot point. We are pretty much agreed as to the facts, and the controversy is mainly as to what they imply. A dualist is, I suppose, one who holds that there exist two quite distinct and independent contagia, one of which produces a non-infecting sore, and the other syphilis. An unicist holds, somewhat differently, that the poison of the soft sore is a product of syphilis, and by no means independent. The difference after all is not great, nor clinically is it of much importance. No one thinks that there are two forms of syphilis, and no one doubts that there are two kinds of sores. Are they related and independent? that is all that we dispute about.

The fact which chiefly favors the creed of those who think that that they are independent is, that the secretion of the chancroid is very contagious, and always produces a sore like itself.

Danielsen tried the practice of inoculating chancroid on a number of lepers who had never had syphilis. He found that he could reproduce a soft sore over and over again, and that it was never followed by syphilis. In further proof that no syphilis was conveyed, it may be stated that one patient, who had undergone many inoculations without ill result, finally by accident received virus from a true chancre, and had, as a consequence, an attack of true syphilis.

All inflammatory products are probably, under favorable conditions, contagious. The gonorrhoeal secretion produces gonorrhœa, that of erysipelas, erysipelas, that of diphtheria diphtheria, and so on. It is probable, however, that each of the diseases may originate spontaneously, and quite independently of contagion. The contagia are, therefore, the products of inflammation. Further, it is highly probable that, in each of the diseases mentioned, the contagium may vary much in virulence, and that it is by no means always the same. Probably it is quite possible to breed them up to higher degrees of power and of special peculiarities. It is possible then that the poison which produces the chancroid is, after all, only a specialized product of inflammation, and not a specific virus.

Many facts seem to support the conclusion just hinted at, and to imply that soft sores are, after all, an appanage of syphilis. When care is taken in inoculation, unquestionably they seem to breed true; but this is not the case in those which we see in practice as the results of accidental contagion. If we place in one group as "soft" all the venereal sores which do not harden, and which do not infect the system, we shall find that but a very small proportion of them present what are considered typical characters of the chancroid. We encounter a great variety of conditions and great differences in course, and are obliged to conclude that they agree in one feature only—the absence of hardness. The rounded form, punched out and ragged edges and gray base, are conditions not present in my experience in one of five of the venereal sores which do not harden.

It would be waste of time to attempt to describe the multiform character of non-indurated sores. Many of them are small, almost level with the surface, and have shelving edges. How rarely do we witness the inflammatory bubo tending to abscess which is said to accompany them. How short, as a rule, is their duration. Whilst the typical chancroid goes through stages, and usually lasts six weeks, a few dressings with iodoform suffice to cure in a week almost all the "soft sores" that we meet with in practice. Now and then, I admit, we encounter the true chancroid as graphically depicted by Mr. Lee, but it is very exceptional. This want of uniformity in conditions is a strong argument against specificity. Another equally strong argument is that the true chancroid on the genitals is seldom seen, except in those who have had syphilis already. If a person who has never suffered before contracts a venereal sore of any kind, it is highly probable that it will lead to syphilis. In using this argument, I by no means wish to deny that the typical chancroid is sometimes seen in those who have never had syphilis.

Very important evidence as to origin of the chancroid, and of all non-indurated venereal sores, from syphilitic secretions, is afforded by at least two experimenters. Mr. Morgan, of Dublin, inoculated with purulent vaginal fluid from those who have had syphilis, and found that he could with it produce the typical chancroid. From the sores thus produced, he could inoculate repeatedly and with



sameness of results. With praiseworthy caution, he never inoculated excepting in those who had previously had syphilis; and thus, whilst his facts are conclusive as to the production of soft sores, they do not prove that syphilis might not very possibly have been produced at the same time had the soil been suitable. Mr. Lee had previously recorded the possibility of producing from indurated sores, by artificial irritation, a secretion which is purulent, and which is inoculable on the patient, producing a sore not distinguishable from chancroid. Mr. Gascoyen, Bidentkap, and others had, I believe, done the same. It is surely very difficult to get over these facts; whilst, to push the argument further, so far as I can see, all *a priori* probability favors the suggestion that non-indurated sores are produced by the secretion of true chancres, which have been changed in character either by the inflammatory process, or by the non-susceptibility of the tissues of the recipient.

#### *Phagedæna.*

A parallel of much importance might, perhaps, be drawn between the chancroid processes and phagedæna. All will admit that syphilitic inflammations have a remarkable tendency to become phagedænic. This may occur in all stages of syphilis, and to all kinds of sores. Is it not necessary that there should be any contagion of material from phagedænic sores; it is sufficient that there is syphilis, for syphilis in its purest form often leads to phagedæna. Phagedæna, as we see it in connection with syphilis, is almost invariably of spontaneous origin, or, in other words, caused by syphilitic inflammation, and not by phagedænic contagion. There is every reason to believe that its products are contagious, and that they would probably produce phagedæna, and not syphilis. The specific virus of the latter is probably destroyed in the gangrenous process. When phagedæna spreads as such by contagion, we encounter it, as I shall have to assert directly, under other aspects, and not as a venereal disease. Now, the chancroid type of inflammation is possibly only a sort of minimized phagedæna, and differs from it only in degree. Its virus is probably produced under similar conditions, and it is curable under the same methods of treatment. The fact that a chancroid in a woman does not absolutely disqualify for sexual congress, makes it possible for it to be transferred as such by direct contagion. This fact it was which misled Bassereau and his followers into the belief that the virus of these sores possessed specific individuality. Probably it is not so; and it is still likely that many chancroids originate spontaneously in the same sense that phagedæna does; that is, they result not from contagion of a sore of the same kind, but from a modification of a syphilitic inflammation by peculiarities of the individual. Be this as it may, it is to be freely admitted that chancroids are very contagious, and that they reproduce themselves with closely similar features. Their virus, if not specific, is at any rate well specialized.

#### *Hospital-Phagedæna.*

Closely connected with this topic, and of great clinical interest, we have the question of the origin of hospital-phagedæna from syphilis. It is not uncommon to see the disappearance of hospital-gangrene claimed as one of the triumphs of antiseptic practice. I hold this to be a mistake. The truth respecting hospital-phagedæna is, that it did not exist in one of ten of our hospitals at the time when antiseptics came into vogue. It is not a disease which is always with us, but rather one which comes occasionally, prevails extensively, and then disappears. It is not due to neglect of cleanliness, nor to atmospheric infection; it does not occur from overcrowding; but it is caused by a special form of conta-

gious pus. The suggestion that hospital-phagedæna take its origin from syphilitic phagedæna, would fit well with the fact that it often prevails in military hospitals, especially when crowded, in time of war.

Accepting the hypothesis of its syphilitic origin, we have then a parallel fact to what is observed in the case of the chancroid. A specialized contagium (pus) has been bred up, which can produce its like wherever inoculated, but which does not contain the virus of syphilis. Both the chancroid and the phagedæna are the products of a poison originating in syphilitic inflammation, but which in neither case can induce syphilis. It is easy enough to see that, if once the particulate virus of syphilis have died out of a secretion, the latter may then be propagated over and over again without the slightest possibility of reproducing the defunct specific elements. It is not, therefore, to be wondered at, that neither the chancroid nor hospital-phagedæna, although appanages of syphilis, ever, when once negatively specialized, by any chance produces that disease.

It is a question about which there is still some debate, whether the infecting or the non-infecting sore is the more liable to phagedæna. My own experience would lead me to a very definite opinion, that almost all sores which are attacked by this process are true chancres, and that it occurs at a stage too late to prevent absorption. It is, in fact, a concomitant of a true syphilitic inflammation, and does not usually happen until induration has taken place. It denotes unusual susceptibility to the influence of the virus, and it is often followed by very severe secondary symptoms. I will by no means deny that the retention of irritating secretions, as in phimosis with concealed sores, may give rise to gangrene of the foreskin in cases where no syphilis exists. If, however, a typical phagedænic process be set up, and spread, I believe that it will almost invariably be in association with true syphilis. I have suggested that the chancroid process is allied to that of phagedæna; but it appears to be well specialized, and quite capable, under most circumstances, of maintaining its individuality. When once its peculiarities have been declared, the sore seldom deviates much from its type. If it do become aggravated, and spread at its edges, such spreading is only of the very mildest form of what we mean by phagedæna.

A knowledge of the fact that phagedæna usually goes with true syphilis is of much importance for purposes of retrospective diagnosis to those engaged in medical practice. Not unfrequently, with symptoms of visceral or nerve disease, an examination of the genitals is made in order to seek for scars. Whilst some have assumed that scars on the penis, or its extensive malformation by bygone phagedæna, imply the probability of syphilis, others have asserted that they rather favor the belief that the disease was not true syphilis. My vote would go with those who regard them as important, though not conclusive, evidence of constitutional disease. I have very seldom seen scars on the penis in patients who had not had syphilis, and still more seldom the evidences of phagedænic action.

I am compelled also, as the result of personal observation, to deviate yet further from the popular creed, and to say that I should regard scars in the groin as also presumptive evidence of syphilis. Our rules of diagnosis have been, I cannot but think, far too definitely laid down on these matters. In private practice it is very rarely indeed that we have to deal with inflamed bubos. It so happens that, of late years, almost all the cases of suppurated bubo which I have seen were cases of syphilis. It is not, I believe, on the other hand, very exceptional for the typical chancroid to cause no enlargement of the glands at all. That an uninfamed

indurated sore will be attended by uninflamed indurated glands I fully admit; but the fact remains, that a great many infecting sores do inflame and suppurate, and when that is the case the glands will follow suit. Nor is this inflammation always the result of a mixed contagion. It often, I feel sure, results from personal proclivity in connection with a fairly pure syphilitic virus.

A series of cases of syphilis from circumcision, which I have recently, in association with my friend, Mr. Charles Macnamara, had an opportunity of investigating, is of much interest in reference to the question just discussed. We were shown a group of six infants, all of whom had constitutional syphilis, having been infected by the same operator in the rite of circumcision. In all the operations, the wound had reopened, and assumed the conditions of a chancre. Two out of the six had double suppurated buboes in the groin, and two others had large masses of agglutinated glands. The children had all been healthy before the operation; and I cannot but think that their age had probably much to do with the unusual tendency to suppurative inflammation displayed.

The recognition of non-infecting venereal sores on other parts than the genitals, whether on the hands or elsewhere, is a matter of great difficulty. I have myself very seldom indeed seen sores on the fingers of surgeons which could be reasonably supposed to be due to vaginal infection, which did not prove to be true chancres. I do not recollect a single instance in which a sore on the hand, which was not a true chancre, produced a bubo in the armpit. Although I have treated possibly a hundred cases of chancre on the finger, I never yet was concerned with a suppurated bubo in the armpit in association with a venereal sore on the hand. This is a very remarkable fact, and may be held to indicate either that the so-called "soft sore" is rare on the fingers, or that it but rarely causes bubo. Probably both explanations are in turn true.

#### *Second Attacks.*

In 1839, Ricord made the important observation that a person who had once had syphilis was not liable to have it again. Although he believed that exceptions to this law were possible, and was anxious to admit them, yet, up to 1858, he had met with none which satisfied his mind. In the following year occurred the first case in which he himself witnessed and treated two attacks of undoubted constitutional syphilis in the same patient. The interval was nineteen years. Diday recorded many exceptional cases, and thought that the second attack occurred when the first was incomplete, and in some sense supplemented it. Thus, if the patient's skin had suffered in the first, and his mucous membranes escaped, the reverse would be the case in the second. Later on, Gascoven and Fournier published many exceptional cases. I have myself seen many in which the patient's narrative was clear that he had had a former attack, and several in which I myself attended the patient in both. It is, I think, now generally accepted that second attacks after considerable intervals are not very uncommon; but, at the same time, that Ricord's law holds good in reference to a very large majority. The exceptions—that is, second attacks—are probably not more frequent than in the case of variola and measles.

As a rule, when a patient contracts syphilis a second time, it is after an interval of many years, and after, apparently, very perfect recovery. Neither of these statements is, however, absolutely true; I have seen a well characterized indurated chancre due to fresh contagion, within a year of the first, and before the patient was well rid of his symptoms. I have repeatedly seen them in those who still suffered from reminders of their former attack.

I have had in my own practice the following case: A gentleman contracted a chancre in February, and took mercury until the hardness disappeared, but no longer. In May, he had rash and sore throat, and again took a short course of mercury. Having left it off for a month or more, he returned, in July, with another chancre, which he believed to be the result of a fresh contagion which was not in the site of the former one, and which presented the most characteristic induration. This sore yielded but slowly to mercury, and was followed by rupia, and eventually by periostitis.

#### *Incubation Periods.*

It may seem strange that, after the amount of attention which the natural history of syphilis has received from many excellent observers, the length of the incubation-period of chancre should still remain a moot point. The differences of opinion are, however, very great. Thus, Ricord said that induration occurs most frequently during the first or second week after contagion; never before the third day, nor after the third week. Sigmund, of Vienna, dealing with 261 observations, found only three with an interval as long as three weeks, and none with longer; whilst in as many as seventy-one it was only nine days. Other observers have given longer periods. Mr. Berkeley Hill, making use only of experimental inoculations, has constructed for us a table which seems to prove that the average period is twenty-four days, the extremes being ten and forty-six. This table comprises thirty-seven cases. Fournier and Clerc give it as twenty-one days. It is admitted that neither differences in the source of contagion nor in the part affected make any difference in the length of the period during which the poison remains quiet. If I were to speak from my own experience only, I should be inclined to make the incubation period longer than any of the observations just quoted, and am obliged to admit that the statements of Sigmund and Ricord are almost inexplicable. I can only suppose that there has been some misunderstanding as to what phenomena constitute the limits of that period, or that it has even been counted, not from the date of the contagion, but from the first appearance of a sore. In this last supposition I am countenanced by Dr. Taylor, of New York, the very able editor of the last edition of Bumstead's work. If by incubation-period we mean, as I contend we ought to do, the interval between contagion and the production of an induration which can be diagnosed, then I believe we shall seldom find it less than five weeks, and more often six. If we date to the first appearance of a sore, then it will be a week or ten days shorter, for the development of hardness takes that time. In these statements we, of course, put aside the very numerous cases in which a sore is present almost from the first, the chancre having been a mixed one.

#### *Recurrent Chancres of False Indurations.*

In connection with the doctrine as to second infection, it is very needful to appreciate the fact that chancres may recur. Briefly, it is quite possible, and not a very rare occurrence, for indurations to develop in the retrocoronal fold of the prepuce, which assume the most exact resemblance to hard chancres, but which are not consequent on any fresh contagion. They occur to those who have had syphilis, and usually, but not invariably, on the site of former chancres. They may happen repeatedly to the same individual, and cases in which this occurs afford the clearest proof that they are not newly contracted sores. They may occur at very various periods after syphilis, but usually within five years. Thus they are not to be associated with



the phenomena which are definitely tertiary; at any rate, not so in many instances. Nor do they, as a rule, resemble tertiary gummata in the tendency which the latter have to grow irregularly and to a large size; nor do they usually break down or slough like gummata. For the most, they retain throughout the most exact resemblance to the ordinary collared chancre, and they are often wholly without ulceration. For myself, I have never, with one exception, seen them in any other position than that mentioned, the fold of mucous membrane just behind the corona, the most ordinary position for the best characterized primary sores. No doubt the development has something to do with the anatomical peculiarities of this part. Under mercurial treatment they melt away very quickly, and they are, I think, rarely attended by enlargement of glands, and never followed by constitutional disease.

The case in which a chancre, not on the penis, recurred was one in which disease had been due to vaccination. In this instance, about four years after the first disease, one of the scars, which had for long been perfectly sound, again inflamed and became dusky and slightly hard at its edges. Mercury very quickly, as a rule, but not always, takes away these recurrent chancres, and they are not, I believe, usually attended by any other proofs of tendency to recrudescence of the constitutional taint. I have known at least one instance in which a gentleman had his chancre indurate again repeatedly during several years, and generally with about a year's interval between the attacks, and yet he remained otherwise in perfect health. I am not sure that, in some cases, the induration may not subside spontaneously, but I have never tried the experiment of leaving them without treatment.

*On Induration as a Symptom and on Syphilis without Chancre.*

That we have been in the habit of attaching far too much importance to the condition of induration as an almost essential characteristic of the initial lesion of syphilis, the observers of to-day are, I think, pretty well agreed. When a sore takes on induration, it is, provided, first, that the patient has never had syphilis before, and, secondly, that no caustic has been used, a certain indication of coming syphilis. But the absence of induration goes for very little in the way of evidence, and it may vary in degree and in duration within very wide limits indeed. In many cases, it lasts only a very short time, and is only very doubtfully marked; in others, it may, in size and duration, simulate a new growth.

If, however, we admit all this, we may still hesitate to admit that syphilis can begin without any chancre whatever. Yet for practical purposes that is the conclusion to which we must come. In other words, there are cases in which the closest scrutiny, aided by a patient who is not only candid but skilled as an observer, wholly fails to discover any initial lesion. These cases divide themselves into two groups, those in which an attack of gonorrhœa preceded the constitutional symptoms of syphilis, and those in which no local disease of any kind was observed. Both of these groups are, I believe, fully recognized by most authorities. Respecting the last, it is undoubtedly possible, indeed, in most instances, probably true, that a chancre had been present and had escaped recognition. Thus in the mouth, and especially on the tonsil, a sore, which was really the primary one, may not have been noticed until other symptoms appeared, and may then have been counted as part of the secondary group. I have seen several instances of this. On the genitals in women very frequently, and in men sometimes, a small indurated sore may cause such slight irritation that its existence is never discovered. But, making every possible allowance for such sources of fallacy, there

still remain a few cases in which careful observation from the beginning has quite failed to find a sore, and in which every possible region has been<sup>s</sup> searched. Is it possible that intra-urethral chancres may occur without pain, without signs of obstruction, without external hardening, and without discharge? Such is the suggestion of some, but it does not seem very probable.

### *Gonorrhœa-Syphilis.*

The frequent occurrence of cases in which syphilis follows what was considered to be only gonorrhœa, suggests the suitability of recognizing what we might call gonorrhœa-syphilis. It is known to all that Hunter regarded the poison of gonorrhœa as identical with that of syphilis, and, no doubt, it was the occurrence of cases such as I now refer to which had caused his belief. There is no danger now that the name I have proposed should mislead any into adopting again his erroneous generalization. Cases of gonorrhœa-syphilis must be familiar to all who have opportunities for observation. The urethral inflammation is exactly like that of gonorrhœa, and by no means suggests a urethral chancre; and, in many cases, the urethra has been examined carefully with the hope of discovering local induration or a tender spot without result.

Mr. Hill has recorded an interesting case, in which the only initial lesion discovered was a general hardening of the whole penile urethra (presumably with gonorrhœal discharge). In explanation of these facts, it may be admitted at once that there is nothing in the least improbable in the supposition that the particulate virus of syphilis may exist in gonorrhœal pus. If a patient, the subject of secondary syphilis, should contract gonorrhœa, no doubt the virus would pass into the discharge, since we know that it is present in the blood, and finds its way into all products of inflammation. Witness its presence in the transparent lymph of the vaccine vesicle. Given, therefore, a person suffering from both gonorrhœa and syphilis, what would be the probable result of contagion? Very likely, as is often seen, a gonorrhœa immediately and a chancre four or five weeks later; but if the latter were omitted, it is still conceivable that the gonorrhœa might allow the absorption of the virus. Possibly, the acute inflammation of the urethra may act in preventing the local adhesive inflammation, which constitutes the conspicuous part of a chancre. This seems a more probable hypothesis than that the virus is absorbed directly, without the intervention of any sore at all. It is to be noted that in gonorrhœa-syphilis there occurs usually definite induration of the inguinal glands.

### *Syphilis conveyed in Vaccination with Clear Lymph.*

A question which was a few years ago in dispute, but which has, I may say unfortunately, been finally set at rest, is the possibility of conveying syphilis by translucent vaccine-lymph. The belief that it was necessary to draw blood, or, at any rate, to allow the vesicle to drain after emptying it, and thus permit the escape of fresh leucocytes, can no longer be entertained. One of our own profession, with that enthusiasm for knowledge which Hunter displayed in a parallel experiment, made himself the victim, and placed the facts beyond the reach of doubt. The facts of the case are probably known to many present; but as they may be new to some, I may be permitted to relate them. They came under my personal cognizance, but, for obvious reasons, I do not mention names. The gentleman to whom I refer vaccinated his own arm repeatedly, and in many places, from syphilitic infants, being very careful on every occasion to use only clear lymph. On the first two occasions he

failed, but on the third he succeeded, and three indurated chancres were the result, followed in due course by constitutional symptoms. The incubation-periods I have already mentioned, the punctures inflamed on the twenty-third day, and were well indurated on the forty-first. It is impossible not to admire the self-devotion which prompted to this experiment, and especially to the perseverance and repetition of it. Had that repetition not taken place, and had a report of results been given to the world after the first two trials, how strong would have been the conviction of all in the truth of the creed that pure lymph, even from infected vaccinifers, is safe. Not often, probably, has our science had so near an escape of being encumbered by a false fact.

The interest of this demonstration does not end with its relations to the practice of vaccination. It proves that the virus of syphilis may exist in a perfectly clear fluid, and in company with that of another specific fever. We know from experiments that if the purulent secretion of soft sores be filtered so as to get rid of pus-cells, it is no longer inoculable. The converse is probably true of the virus of syphilis. The contagium of the one is pus, that of the other the particulate micro-parasites of a specific fever.—JONATHAN HUTCHINSON, *Brit. Med. Journal*, Jan. 9, 1886.

### NERVOUS TROUBLES IN SLOW MERCURIAL INTOXICATION.

1. SLOW mercurial poisoning gives rise to a certain number of nervous troubles which constitute the greater part of its symptomatology.

2. These nervous troubles can be attributed, in part, to the presence of mercury in the nervous centres, where it has frequently been found, and in part to lesions of the cerebro-spinal system, which have been described by Wising. One of the most curious characteristics of these lesions is the persistence of the axis cylinder in the altered regions. This last condition is found in the lesions of sclerosis in plaques, which, moreover, in its clinical features shows some analogies with cerebro-spinal hydrargyrosis.

3. The nervous troubles of hydrargyrosis are :

a. Disturbances of motion : trembling analogous to that of sclerosis in plaques; convulsive phenomena of various kinds (cramps, epileptiform attacks, etc.), choreic movements, apoplectiform ictus, paralyzes presenting the features of paralysis of cerebral origin.

b. Disturbance of sensibility : anæsthesia presenting the features of anæsthesia of cerebral origin: painful phenomena of which the most constant are the arthralgias and cephalalgias.

c. Disturbances of a psychical nature which are at first excessively emotional: disturbances of sleep, vertigo, and, toward the last, dementia very much resembling senile dementia.

4. In general, these nervous disorders persist for a very long time; they may be greatly benefited, but only rarely can an absolute cure be obtained.—PHILIPPE MARÉCHAL, *Thèse de Paris*, 1885.

### STUDY OF GENITAL HERPES IN MAN AND IN WOMAN.

1. GENITAL herpes is almost as frequent in women as in men.

2. In women, the eruption is more abundant; in men, confluent eruptions are excessively rare.

3. In man, recurrent herpes is quite common, while in the woman it is symptomatic herpes that we observe in the larger number of cases.—NUMA PINTO, *Th. de Paris*, 1885.

### THE PREVENTION OF GONORRHEA.

ALTHOUGH it has generally been the view of physicians that, aside from the regulation of prostitution, it has not been a part of their duty to prevent infection from venereal diseases, the alarming increase of these maladies, and their resulting evils, have tended to make prophylactic measures much to be desired.

Dr. Haussmann (*Deutsche Med. Wochens.*, No. 25, 1885), of Berlin, was led from his observations of the efficacy of nitrate of silver in preventing gonorrheal ophthalmia in infants born of women suffering from gonorrhœa, to extend its use to the prevention of the latter disease in men after exposure.

He found that an injection of a two-per-cent solution of nitrate of silver into the urethra, at most a quarter of an hour after cohabitation with an infected woman, has proved a very effectual means of preventing infection. He recommends further investigation into this field, which, although subject to severe criticism from moralists, certainly does present a practical side.

Dr. Martineau recommends (*Bull. de Thérap.*, Nov., 1885) as a prophylactic a solution of bichloride, 1 to 500, to be used as a wash and injection. He advises that the prostitute should have the solution in her room to be used by both parties, both before and after coition. His formula is:

R Hydrarg. bichloridi.....	2 pts.
Ammonii chloridi.....	6 “
Alcohol.....	200 “
Aquæ.....	ad 1000 “

M.

The application of this solution, while innocuous, is very efficacious in its action upon the gonococcus.

---

## Reviews.

---

TRANSACTIONS OF THE ACADEMY OF MEDICINE IN IRELAND, VOL. III. Edited by WM. THOMPSON, M.A., F.R.C.S. Dublin: Fannin & Co., 1885.

The transactions of the Academy of Medicine in Ireland for 1885 comprise a large number of valuable contributions which are highly creditable to the scientific research and activity of the members of this body.

Of special interest to dermatologists may be mentioned a paper on “Lupus and its Treatment,” by Dr. Walter G. Smith; “Tar Cancer,” by Dr. C. B. Ball; “Epithelioma of the Eyelid resulting from irritation by crude carbolic acid,” by Mr. J. B. Story; “Sub-Lingual Epithelioma,” by Mr. K. Franks; “On so-called Malignant Growths,” by Mr. George Fry, etc.

Many of the papers are admirably illustrated, and the volume is well printed on good paper, presenting a handsome appearance.

VENEREAL MEMORANDA: A MANUAL FOR STUDENTS AND PRACTITIONERS. By P. A. MORROW, A.M., M.D., etc. New York: William Wood & Co., 1885.

The title of Dr. Morrow's little book does not express the full scope of the author's design. By *Venereal Memoranda*, one might infer that the book was



simply a collection of such elementary facts relating to venereal disease as a student would need to memorize. But the author's aim was evidently more ambitious than this. By epitomizing the materials embodied in the vast literature of the subject, embracing as they do a very great variety of topics and disputed questions, the writer has succeeded in producing a work which has for the practitioner the value of a reference book. The different subjects are presented in a series of short and carefully composed paragraphs that for the most part take the form of aphorisms, a form which seems well adapted to the writer's purpose, but is liable to lead to dogmatism. Of this danger, however, the writer appears to have been fully aware. The labor involved in his undertaking was doubtless much greater than is at once apparent, on account both of the extent of the materials and of the unsettled state of many questions concerned. Considering the nature of the work, the author's judgment and discrimination are entitled to much credit.

Not only can these "Memoranda" be confidently recommended to the undergraduate, but also to the busy practitioner, who would in a convenient form have access to the best accredited views on venereal subjects—views that otherwise he would be obliged to extract by a laborious process from many writings which may not be at hand or which, perhaps, he has no time to consult.

The typography and general appearance of the book leave nothing to be desired. E. B. B.

## Books and Pamphlets Received.

Transactions of the Medical Society of the State of Pennsylvania at its thirty-sixth annual session. 1885, Vol. xvii.

A Case of Multiple Sarcoma of the Skin, by C. A. CHEEVER. Reprint.

Beitrag zur Therapie der Leucoplakia, von DR. JOSEPH.

Pruritus Cutaneous Unilateralis nach Gehirnembolie. Idem.

Ein Fall von erworbener idiopathischer Atrophie der Haut, von DR. K. TONTIN, in Wiesbaden.

Ueber Saponimente oder Medicinische Opodeldoken, von DR. LETZEL, München.

Del Rinofima, del Prof. PIETRO GAMBERINI.

Syphilis der Trachea und der Bronchien, Pneumonia Syphilitica, von Dr. CARL KOPP.

Ueber die Behandlung der Syphilis mit Subcutanen Injectionen von Hydrargyrum formidatum, von Dr. CARL KOPP.

Ueber den gegenwärtigen Stand der Lehre von dem Resorptionsvermögen der menschlichen Haut, von Dr. C. KOPP.

Ein Fall von multipler Sclerose des Gehirnes und Rückenmarkes in Folge von Syphilis. Die Merckseife, von Dr. SCHUSTER.

Syphilis des Verriërs—Falsification des Matières Alimentaires etc. Par E. BESNIER.

Treatment of Lupus by Parasitocides, by JAMES C. WHITE. Reprint.

Angioma Pigmentosum et Atrophicum. Idem. Reprint.

Three cases of Xeroderma Pigmentosum (Kaposi) or Atrophoderma Pigmentosum, by H. RADCLIFFE CROCKER. Reprint.

## Items.

**THE TREATMENT OF FURUNCLES.**—M. Hardy recommends, *Gazette des Hôpitaux*, both local and general treatment. Locally he uses: 1st, poultices of rice flour, or bread and milk, but not linseed meal; and repeated bathing; 2d, maturatives, such as *Onguent de la mère* (composed of olive oil, lard, butter, suet, yellow wax, litharge, and pitch), ungt. digestivum, ungt. styrax, adhesive plaster, or emplastrum hydrarg. de Vigo. He does not open the boils, except when they take a slow course. He believes that there is no use in trying to abort the boil with tincture of iodine, nitrate of silver, etc. For internal medication against the furunculous diathesis, he advises the use of tar water with the meals; oil of cade in pills or capsules; sodæ bicarbonatis ʒi. before meals; alkaline waters, and Fowler's solution. Attention to hygiene is of the most importance.

**PRURITUS VULVÆ.**—Dr. Julien's formula for pruritus vulvæ is as follows:

℞ Zinci oxidi ..... 25 grams.

Acidi salicylici..... 1 gram.

Glycerini amyli..... 25 grams.

M. Sig. Apply as needed.—*Paris letter in Phila. Med. Times.*

## FOR IMPOTENCE.—

℞ Ext. cannabis ind..... gr. x.

Ergotin (aq. extr.)..... ʒ ij.

Ext. nucis vomica..... gr. x.

Ft. pil. No. xx.

Sig. One morning and evening.—*BARTHOLOW, Col. and Clin. Record.*

**A LITTLE LEARNING IS A DANGEROUS THING.**—The smart young lady who wrote a note to the doctor, asking him to visit her brother, and bring his urethra with him, has been discounted by a well-informed medical student of Indianapolis, who was asked recently by his sweetheart to examine her throat for some slight ailment. Being anxious to exhibit his embryonic medical talents to his fair'inamorata, he called for a spoon, dexterously depressed her tongue, gazed knowingly into the yawning chasm thus brought into view, and then, with a look of profound wisdom, informed her that *her vulva was greatly elongated.*—*Ind. Med. Journal.*

**TREATMENT OF ITCH.**—Comessati recommends the following treatment of itch as more simple and successful than any other hitherto used (*Journal de Méd.*, No. 4, 1885): 200 grams (6½ oz.) of hyposulphite of sodium are dissolved in a litre (Oij.) of water, and the entire body, before retiring, is treated with this solution. On the following morning the body is treated with a solution containing 50 grams (2 oz.) of hydrochloric acid in a litre of water. The explanation of this treatment is very simple: sulphur in a state of fine division settles in the pores and remains there for a long time; sulphurous acid and chloride of sodium are also formed. These two results of this reaction are both toxic to the acarus, and the affection is usually cured by a single application.

**TURPENTINE IN MALIGNANT TUMORS.**—Prof. Vingt, of Barcelona, employs a hypodermic injection consisting of one part of turpentine and two parts of alcohol in carcinoma and sarcoma, and has frequently succeeded in causing these neoplasms to disappear. A local inflammation with fever, lasting about eight days, was the usual consequence of the injection.—*Revista de Ciencias Medicas*, No. 1, 1885.





Dr. Morrow's Case  
of  
Iodide of Potassium Eruption.



# JOURNAL

OF

## CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

APRIL, 1886.

No. 4.

---

### Original Communications.

---

#### THE BULLOUS FORM OF IODIC ERUPTION.<sup>1</sup>

BY

PRINCE A. MORROW, A.M., M.D.

Clinical Professor of Venereal Diseases, University of the City of New York, Surgeon to Charity Hospital, etc.

**C**OMPARATIVELY few cases of bullous eruption caused by the ingestion of iodide of potassium are found recorded in the literature of drug eruptions, and it may therefore be classed among the rarer cutaneous manifestations of the drug. A most remarkable case of this eruptive form recently came under my observation at Charity Hospital.

The patient, Albert Stout, a German, about fifty years of age, was transferred to the Dermatological Ward, October 9, 1885. Upon admission the entire face, the ears, and the neck down to the level of the hyoid bone were found to be the seat of an eruption, also the dorsal surface of hands and wrists. The integument of the forehead and face was bright-red and infiltrated to such a degree as to be a quarter of an inch thicker than normal, causing the natural lines of the skin to appear like deep furrows. The skin appeared as if thrown up into prominent bosses or ridges, separated by intervening depressions. The enormous tumefaction of the supra-orbital folds gave a leonine appearance to the face. The eyes were closed from the œdematous condition of the upper and lower lids.

The face, and especially the forehead, was thickly studded with small vesico-pustules, many of which had broken, leaving a mass of crusts. Upon the upper portion of the forehead the fusion of the closely-crowded bullæ had formed a belt or zone of raised epidermis, simulating in appearance the advancing border of an erysipelatous inflammation, which

<sup>1</sup> From a forthcoming work on "Drug Eruptions." Wm. Wood & Co., Pub'rs.

stopped abruptly at the line where the hair began. The dermatitis, both of the face and posterior portion of the neck, did not encroach upon the hairy scalp. The swollen alæ of the nose were covered with a number of pea-sized lesions, some of which had become pustular. The ears were greatly swollen, and where the crusts from ruptured bullæ had been picked off by the patient, bloody crusts were to be seen. The skin became pale on pressure, but did not pit, and immediately resumed its red color when the finger was withdrawn.

Upon the dorsal surface of the hands and wrists, the skin was reddened and infiltrated, though not to the same degree as upon the face. On the dorsum of the left hand, from the wrists to the tips of the fingers, were a number of bullæ varying in size from a three-cent piece to that of a silver dollar.

Upon the right forearm above the wrist there was one large bulla and two smaller ones, with a few vesico-papules. The back of this hand was occupied by a large bulla, the size of a pigeon's egg, surrounded by a number of smaller ones, suggesting in their arrangement a magnified herpes iris; toward the ulnar or outer border were four or five bullæ, ranging in size from a large pea to that of a cherry; the second, third, and little fingers were occupied by bullæ extending along their entire length to the tips, the walls tensely distended with a sero-sanguinolent secretion. Both hands presented a swollen, puffy appearance. There was no eruption upon any other portion of the body. Examination of the mouth and fauces revealed nothing beyond an intense congestion of the mucous membrane. The patient was in a state of profound prostration; he was dull and stupid and could be aroused with difficulty; there was more or less tremor of the hands, and he was constantly moving them toward his face. His respiration was quickened and his pulse was 120, temperature not taken.

In the presence of a case presenting eruptive features of such unusual intensity and development, and which could not be identified with any of the ordinary dermatoses, I made the diagnosis of "iodide of potassium eruption," although it was not known at the time that the patient had been taking the drug.

Upon making my visit the next day, I was furnished with a history of the patient previous to his transfer to my ward, which my House Surgeon, Dr. A. Talbot, had procured from the records of the Nervous Hospital. I am also indebted to him for the notes, from which the subsequent history of the case is condensed.

"The patient was admitted to the Nervous Hospital (Par. O. & P. Depart.) on Sept. 23, suffering from incomplete paraplegia. There was no history of syphilis or of any skin disease except rosacea, evidences of which were present in the shape of a slight acneiform eruption. The patient was ordered a solution of iodide of potassium (1 in 2) 3 i., t. i. d. This was stopped on Oct. 4, after he had taken 900 grs. altogether. Three or four days after beginning the use of the iodide there was observed an erythematous condition of the face, with the production of vesico-pustules about the size of a small pea. About October 1, an eruption appeared upon the backs of the hands. Under the continued influence of

the medicine the dermatitis increased in intensity and severity, and the vesicles developed into bullæ of varying size. The iodide was discontinued Oct. 4, and for four days the patient was given pills of calcei sulphidi  $\text{aa } \frac{1}{2} \text{ gr.}$ , one three times a day."

Oct. 10. The general appearance of the condition upon the face was about the same as yesterday. The bullæ upon one hand had become coherent at their bases, but did not coalesce. Upon the other hand the lesions had become confluent, forming an enormous blebs extending from the annular ligament of the wrist to the tips of the fingers. The color was a steely blue, bearing a striking resemblance to the appearance of a coil of intestine. The general condition of the patient unchanged; resp. 23, pulse 112. Catheter will not pass on account of stricture at  $4\frac{1}{2}$  inches, admitting No. 10 sound with difficulty. Urine duck kept in bed with patient. He was placed upon an extra diet and ordered whiskey  $\text{§ iv.}$  per diem. The face and hands to be dressed with carbolized vascline. Some of the bullæ were punctured, yielding a reddish serum which was examined for iodine with negative results.

Oct. 11. No change in appearance except that some of the older bullæ on hands have become dirty-blue in color, and on puncture give exit to a dirty-red sero-pus instead of a clear serum as before. Examination of heart showed a systolic apex murmur transmitted toward left axilla. Diagnosis of mitral insufficiency. Temperature,  $100.1^{\circ}$ ; resp., 22; pulse, 114.

Oct. 12. Infiltration of the skin has subsided somewhat; examination of the urine shows it acid in reaction, sp. gr. 1.010, with a considerable amount of albumin, 10 to 15 per cent. Under the microscope a few pus and blood globules are seen; no casts.

Oct. 14. On the back of the neck the skin has returned to its normal level, but is still red, the face less swollen, eyes well open and bright in appearance, leonine appearance of countenance gone. The bullæ on hand present a blue-black coloration. A bloody pus, slightly offensive, comes from one or two ruptured bullæ. All the bullæ were ordered to be cut open, washed out with  $2\frac{1}{2}$ -per-cent carbolic solution, and dressed with carbolized vaseline. The floor of some of the bullæ is bathed in pus, apparently due to superficial ulceration.

Oct. 21. Continued improvement in general condition of patient, the backs of the hands cleared off and presenting a healthy appearance.

Oct. 29. The skin of the neck and a good part of the face has returned to its normal conditions, though still somewhat hyperæmic. Raw surfaces on dorsum of hands and fingers healing.

Nov. 5. Almost all traces of the eruption gone, though no gain in the patient's general condition. Patient has cough. Examination of chest shows dulness at apices of both lungs, with increased fremitus, prolonged high respiratory murmur, and few moist râles. Passes urine and fæces in bed as on entrance.

Nov. 15. Patient has continued to fail. Increasing frequency and feebleness of pulse (120); resp. 32. Examination of chest shows pulmonary œdœma.

Nov. 16. Patient died quietly at 2 A.M.

Autopsy showed *heart* enlarged and dilated on left side. Insufficiency of mitral valve and atheromatous deposits. Aorta atheromatous. *Lungs* œdematous; phthisical consolidation at both apices; no cavities. *Kid-*

*neys* somewhat diminished in size and heightened in color ; consistence increased ; surface granular ; capsule adherent. *Liver* and *spleen* normal.

The drawing representing the face in the accompanying picture was made on the second day after the admission of the patient, when the more acute eruptive features had begun to subside. A photograph from which the drawing of the hands was made was taken after some of the bullæ had ruptured and partially collapsed. The direct dependence of the eruption upon the iodide of potassium in this case would seem to be conclusively established ; first, by the appearance of the cutaneous phenomena within three or four days after commencing the use of the drug ; second, by the intensification of all the eruptive features under its continued use ; third, by the subsidence of the eruption soon after the drug was withdrawn, and, fourth, negatively, by the absence of any other known exciting cause.

It will be observed that while the iodide was discontinued on October 4, the eruption did not attain its maximum development until four or five days later. Whether the sulphide of calcium, given in the interim, exerted any material influence in intensifying and perpetuating the eruptive tendency is open to question. Such an assumption is, however, unnecessary in explanation of the continued development of the cutaneous disorder, since it is well known that a morbid process set up in an organ may continue after the exciting cause has ceased to act. In this case it is probable that, owing to the impairment of the integrity of the kidneys, through which iodine is principally eliminated, the drug accumulated in the system and continued to produce its toxic effect upon the blood and nerve centres for some days after its introduction. It is a well-attested clinical fact that many of the severer forms of iodic eruption occur in patients who are found to be suffering from renal inadequacy and cardiac lesions. Whether the cardiac complications stand in the relation of a determining cause or a mere coincidence has not been definitely determined.

The comparatively slow involution of the lesions in this case was probably due to the profound systemic depression caused by the drug, and the existence of the grave organic troubles which ultimately proved fatal.



ON THE LIMITATION OF THE CONTAGIOUS STAGE OF SYPHILIS,  
ESPECIALLY IN ITS RELATIONS TO MARRIAGE.<sup>1</sup>

BY

FESSENDEN N. OTIS, M.D.,

Clinical Professor of Venereal Diseases in the College of Physicians and Surgeons, New York.

(Concluded from p. 72.)

IN the recent important work on Syphilis and Marriage, published by M. Alfred Fournier, of Paris, in 1880, for the purpose of justifying his statements that "*syphilis is but a temporary bar to marriage*," previously quoted, has presented a series of eighty-seven examples, occurring in his own experience. In presenting the carefully tabulated report of these cases, he says: "For my part alone, I have in my hands, to speak only of written facts, eighty-seven observations relative to syphilitic subjects, undoubtedly syphilitic, who, having married, have never communicated to their wives the least suspicious phenomenon; and, moreover, these 87 have produced among them a total of 156 absolutely healthy children. In examining the tabulated records of these 87 cases at page 231 et seq. of his work (Fournier, "*Syphilis et Marriage*"), I found that 36 out of this number of men, who were thus proven to be free from any power to transmit syphilis, either by direct contact or by heredity, were subjects of late or tertiary lesions *after marriage*, some before, and some after the birth of the children.

These lesions comprise almost all the varieties of the sequelæ of syphilis, thus: gumma of the penis, palmar psoriasis, dry tubercular syphilide, gumma of velum palati, cerebral syphilis, papulo-tubercular syphilide, costal periostitis, cerebro-spinal symptoms, evidently of syphilitic origin, diplopia, passing attacks of hemiplegia, nasal syphilides, ecthyma of legs, syphilitic sarcocele, nasal ulcers, ulcerative laryngitis, papulo-squamous palmar and plantar syphilides, sclerous glossitis, papulo-scaly syphilides of circinate form, tubercular ulceration, syphilide of the nose, etc.

In examining the tables of M. Fournier still further, it was found that the average time of marriage, after infection, in the eighty-seven cases, was  $5\frac{8}{16}$  years; that twenty-five per cent were married within three years after infection, and over ten per cent within two years.

In regard to the length and quality of treatment, over twelve per cent of the eighty-seven cases had treatment of less than a year's duration; several with only a few months, one with the iodide of potash, and another with no treatment at all.

<sup>1</sup> Read at the Annual Meeting of the New York State Medical Society, Feb. 5, 1886.

In this enormous mass of evidence, consisting of eighty-seven authentic examples, involving prolonged observation of two hundred and thirty individuals, adduced by an acute, thorough, and competent observer, we have what I shall claim as absolute truth: first, of the non-contagiousness of all lesions of the tertiary stage of syphilis; second, of the possibility of the spontaneous cure of the contagious stage of syphilis (*i. e.*, without treatment), as shown in one case, where there was no treatment, and in another case, where only the iodide of potash was used. Third, that the limit of the contagious stage in syphilis, may then, it seems to me, be certainly fixed at a point within the period of five years.

For my own part, I have *never* seen a case of syphilis presenting an undoubted lesion of the secondary or active stage after the termination of the second year. I have seen a goodly number of cases of recurring papular syphilide—especially upon the hands and feet, occasionally upon the body—two and three years after an infection which had been thoroughly and systematically treated from the beginning, and I have always considered them as due to damage done to the lymph channels, during the previous active stage of syphilis. After the third year, in three such cases, marriage has been entered into, with my consent; and in two, recurrences in the identical places formerly occupied took place nearly a year after marriage, and in both these cases, the wife remained uninfected, and healthy children were reported, one now three, and the other two years old. I have seen frequent lesions of the tongue, from two to a dozen years after infection, the sequel of mucous patches occurring during the active stage, which had been asserted, by physicians, to be mucous patches, and capable of transmitting syphilis. Sometimes those would present simply as pale pearly stains, or whitish patches, sometimes erosions and ulcerations, and cracks again appearing as irregular spots covered with a white or grayish pellicle with more or less induration. Such lesions I have never known to prove a source of syphilis to others, although coming into most intimate contact, such as between man and wife, for a series of years, during which recurrences had taken place. Hence I do not hesitate to state, that such forms of trouble, occurring as a sequel of syphilis, three years or more after infection, do not contain the contagious property of syphilis, and hence cannot communicate it. I have also seen numerous cases and observed them during long periods, in which marriage has taken place from three to twelve or more years after a syphilitic infection of the father, and I have never yet seen a single symptom of syphilis in the wife or in the children born of such marriage. In the reported cases where syphilis has been claimed to have been contracted from persons whose syphilis had its initiation three or more years previously, I believe that, if the truth could be ascertained, it would be shown that the disease was *not* contracted from such persons, but al-

ways from a source less than three years from date of the infection. The overwhelming evidence, as to the improbability of the communication of syphilis, after the first three or four years from the date of infection, as shown by the statistics of M. Fournier, should lead to the greatest opposition in accepting cases alleged where syphilis has been acquired in contradiction of this position. The traditions of syphilis claim, that once a man has had syphilis he is a possible focus of contagion forever, and any evidence that a man has once had syphilis, is held as competent to prove that any syphilitic accident in his family, to the latest generation, may be reasonably credited to him. The important fact that syphilis may be communicated through other sources, is practically ignored. Syphilis from mediate contagion is common. It may be through the medium of a spoon, a pencil, a cane, a cigar, a kiss, the dentist's instruments. The accoucheur may acquire it through his finger. Nine cases of syphilis of the finger I published several years since as occurring under my own observation, and I have seen others since that time. Besides this, I have seen at least double that number of cases of syphilis, where no possible trace of the source of contagion could be ascertained. A tumbler, or any article in common use, defiled with the secretions of a mouth harboring a mucous patch coming in contact with a crack or abrasion of the lips of a healthy person may communicate syphilis through a resulting lesion which may pass away unnoticed. Any similar contact with the blood of a person in the active stage of syphilis will communicate it. And yet, if the resulting syphilis is not distinctly traced to some one of these sources, the disease, where possible, is referred to some person who has had syphilis, perhaps a quarter of a century before. It is the *tradition*, based upon the everlasting contagious nature of the disease, that the profession are wont to fall back upon to explain the mystery. Even M. Fournier is not free from the tyranny of this unproven tradition. Notwithstanding the convictions that his intelligent experience has imbued him with, that syphilis is not communicated by any person after the first three or four years from infection, and which impel him to state that *syphilis is but a temporary bar to marriage*, and which makes him say, "Yes, a hundred times yes, a man may marry after having had the pox, and the result of such a marriage, under these conditions, may be absolutely safe, medically speaking," yet, Fournier subsequently says: "We must still recognize some rare exceptions where the disease retains its contagious properties indefinitely. Such, for example, is the case of a patient whom I treated some time ago. This young man had been infected with a syphilis five years before, which one could fairly call mild, since the initial chancre was only followed by a roseola, a palmar syphilide of slight intensity, and a sore throat. He treated it almost from the beginning sufficiently well; several times he

submitted, under my advice, to a strong mercurialization (fifteen to twenty centigrammes of proto-iodide daily). Well, in spite of this treatment, and in spite of all my efforts, the patient (who, by the way, is a smoker, a circumstance essential to note) has not ceased to be affected, during a period of five years, with lingual syphilides almost continuously. I cured him of one breaking out; one or two months later a new one attacked the tongue; then came a new treatment, followed by a new cure; then reappearance of the malady, and so on. To be brief, I always cured him, and it always began again, to use his own expression. Now that he has completely given up tobacco at my earnest solicitation, the eruptions become less frequent, but have not altogether ceased; and quite lately I have again seen him with syphilis coming on the back part of his tongue. Now, what would have happened if, relying on the mild nature of his disease, and satisfied as to the treatment followed, I had allowed the patient to marry between the two outbreaks of such symptoms? What would have happened, I need not predict theoretically, because I have had a practical demonstration. This young man took as a mistress last year—a woman who, till then, was perfectly healthy, exempt from every venereal symptom. Some weeks later he brought her to me, affected by an indurated labial chancre, manifestly received from the lingual syphilides of the patient.”

This case, and the only case, is presented as a typical one, to illustrate the possible persistence of contagious lesions after many years, notwithstanding the disease is of mild form, and has been systematically, persistently, and efficiently treated “almost from the beginning.”

Now, is such a conclusion sufficiently warranted by this evidence on a matter of such moment? Let us look at other causes, equally possible, equally probable. The young man did not take for a mistress a woman whose virtue was above suspicion. Such a coincidence as the contact of such a woman's lip with some other lip, with fresher syphilitic lesions, would not be so extraordinary as the acquirement of syphilis from a buccal lesion five years after infection. Such a woman would be quite in line of coming in contact with persons having active syphilis, and either directly or by mediate contagion might have acquired her labial chancre, even if she had not become this man's mistress, without exciting especial comment.

Let me place here in contrast to this, a case taken from my own experience. A young man had undoubted syphilis; from the first under my own observation: characteristic initial lesion, general gland enlargement, roseola, no pronounced papular eruption, mucous patches on tongue and inner surface of feet. After a somewhat desultory treatment of two years, he was apparently well. Remained free from all trouble for two years; then began to have ulceration at the side of the tongue, pearl-



colored at edges, characteristic appearance of the so-called chronic mucous patch; was greatly addicted to tobacco, tongue resisted local treatment, unless accompanied by exclusion of tobacco; repeated recurrences for nearly five years; not markedly affected by specific treatment, which was tried from time to time, when at last he married a virtuous girl. Since that time already four years have elapsed, and the wife has not yet had a symptom of syphilis. As a result of this marriage, there is to-day a perfectly healthy child three years old, and yet within the last month the husband consulted me in regard to a recurrence of the ulceration at the border of the tongue.

M. Fournier ignores entirely the possibility of accounting for the initial lesion of the lip, in the rare case he quotes, in any way except through the chronic lesion, which his history has shown chiefly to be dependent for the difficulty of cure, on the use of tobacco. This one case is placed, squarely, as an offset against his eighty-seven cases, some of which were also cases of ulceration of the tongue, incontestably proved to be free from the contagious element of syphilis by the immunity from infection of the eighty-seven wives and one hundred and sixty-seven children involved. It is true he brings forward a few cases in the practice of other physicians to prove the possible inoculability of late lesions of syphilis, but those, in the face of such statistics as he has given us, are not to be accepted while they are all open to explanation in various reasonable ways, independently of the claim of a contagious element persisting for years from the date of infection. We cannot allow even such an authority as M. Fournier, to force the acceptance, without question, of a conclusion in such direct antagonism with the mass of positive and conclusive evidence that he has given us, of the non-inoculability of the late lesions of syphilis. We are, I assume, fully warranted in claiming, that the explanation of the only case which he brings up directly to prove that the late lesions of syphilis may, in exceptional cases, be contagious, undoubtedly lies in the acquirement of syphilis from a source quite independent of the five-years-old lingual lesions to which he hastily attributed it. Eliminating this case, we have then, a solid mass of evidence, which, on any other point, would be absolutely conclusive. In support of this, we have also the failure of all experimental inoculations with the secretions of the late lesions of syphilis, which have been failures in every instance. We have also the knowledge of some of the various occult ways in which syphilis may be acquired, defying absolute demonstration. In the absence of an old syphilis in the husband, we have various ways of accounting for repeated abortions and pemphigoid infants, upon which rest the diagnosis of syphilis as a cause, when such syphilitic history in the male parent might have been accepted before we knew that the semen did not contain the contagion of syphilis. The great discussion in the Academy of Medicine in Paris, a *résumé* of

which is given by Diday (page 72 of his work on "Infantile Syphilis"), shows that the conclusion was arrived at that "Pemphigus of the fœtus was not an immediate result of syphilis, but an indirect sequel of the exhaustion which this disease produces."

It is true that abortions, and the production of diseased infants, may continue long after the active or contagious stage of syphilis has passed. It seems to me, however, that it is not too much to claim, that this continuance is due to changes produced in the reproductive organs of the female during the early stage of the disease, and should be classed among the sequelæ, which have been proven to be free from the contagious element of syphilis.

With this presentation of some of the facts and arguments which may be brought to bear in favor of a positive limitation of the contagious stage of syphilis to three and at farthest to four years, with or without treatment, I rest my case.

No. 5 West 50th Street.

---

#### A CONTRIBUTION TO OUR KNOWLEDGE OF THE HYDROA BULLEUX OF BAZIN, AND OF THE DERMATITIS HERPETIFORMIS OF DUHRING.<sup>1</sup>

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

**I** DESIRE to present to the Society this evening the history of a case of skin disease which, in my experience, is very rare, and which is of much interest in its pathological and nosological relations, as well as bearing upon its nomenclature.

The following history was kindly drawn up for me by my assistant, Dr. C. W. Cutler.

T. Bush, æt. 29, laborer, Ireland, admitted to Bellevue Hospital, July 14, 1883.

*Previous History.*—The patient had always been a hard drinker, but, until the present illness, has never been sick, except with an occasional attack of articular rheumatism, which has not, however, been severe enough to prevent his working. Two months before admission, he began to suffer from dyspnoea, which at first only troubled him on exertion, but lately has become so severe as to prevent his working, and accompanied with great dizziness and palpitation of the heart; he therefore applied to the hospital for admission.

*On Admission.*—Patient cyanotic, and has severe dyspnoea and

<sup>1</sup> Read before the New York Dermatological Society, Jan. 26, 1886.

cough. Pulse rapid, intermittent, and irregular. Slight œdema of the feet.

*On Examination.*—Heart hypertrophied, valve sounds indistinct and accompanied with a double aortic and mitral regurgitant murmurs. Lungs—Moist râles over both lungs, especially behind (œdema). Urine contains about 5% albumin, not examined for casts. Temperature  $99\frac{1}{2}^{\circ}$ .

July 16.—Patient's condition remains about the same. Bowels constipated. Appetite fair. Urine small in amount. Temp.  $99\frac{1}{2}^{\circ}$ .

July 18.—Patient is slightly delirious at night, but quieted with bromide. To-day an herpetic eruption appeared on the neck, behind the ears, causing the patient much burning pain and smarting. Temp.  $100^{\circ}$ .

July 19.—The eruption has extended, covering the face, neck, and ears. It appears vesicular in character, confluent in patches, and uniting in spots to form large bullæ. A few such spots have made their appearance on the backs of both hands and wrists, but the remainder of the body is entirely free from eruption, as is the scalp. The patient complains much of the heat and pain accompanying the eruption. He is quite delirious, has severe dyspnœa, and was quieted only with opiates. Temp. remains at  $101^{\circ}$ .

July 21.—Eruption has not extended, but is more confluent, is vesicular and bullous in character. Some of these lesions bursting, and secreting a thick, milky-white fluid, which, drying, forms a yellowish scab. The spots making their appearance last are still vesicular, filled with a clear serous fluid, which is gradually turning turbid and milky.

The spots are not surrounded by much redness, but the face is much swollen and disfigured, the eyes being nearly closed, the patient having the general appearance of one suffering from confluent small-pox. No eruption on the mucous membrane of mouth or on the conjunctiva. Dr. R. W. Taylor was called in consultation, and diagnosed the eruption as of vesiculo-bullous character, or hydroa bulleux. Temp. still remains about  $101^{\circ}$ .

July 23.—Eruption is slowly drying, forming brownish scabs. Face less swollen. Patient feels much better, eats and sleeps well. Temp. normal. Some dyspnœa.

July 25.—Dyspnœa very severe, patient being obliged to sit up in bed to breathe, and is passing but a small amount of urine.

July 29.—The scabbing process is nearly complete, many of the crusts having fallen off, and without leaving a scab. Patient stronger, but suffers greatly from dyspnœa.

August 1.—The face and neck have assumed a nearly natural appearance, the scabs having fallen off, leaving the skin red but not scarred. Patient's general condition very poor, is delirious most of the time, passing but little urine, with a large per cent of albumin. Pulse weak and rapid. Temp.  $101^{\circ}$ .

August 3.—Patient died of failure of heart's action.

Here then is a case of a man addicted to alcoholics, suffering from Bright's disease, mitral and aortic lesions with œdema of the lungs, who is admitted to the hospital on the 14th of July, cyanotic to a moderate extent, suffering from dyspnœa and cough, and being slightly anasarcaous. He remains in this condition with a temperature of  $99\frac{1}{2}^{\circ}$ , until the fourth

day, July 18th, when his temperature rises to 100, and an eruption appears behind his right ear. This eruption presents the appearance of typical herpes, a red inflamed base sharply defined, upon which is seated a large number of vesicles containing clear serum, accompanied by a severe smarting and burning pain. In the evening he became delirious. Neither before his entrance into the hospital had he taken any but simple remedies, certainly no drug whose ingestion is followed by a rash. Within twenty-four hours the eruption covered the face and neck, being everywhere at its invasion vesicular in character and quickly developing into bullæ, some prominent and rather larger than a pea, and others broad and flat, as shown in the picture. On the second day, a few vesicles appeared on the back of the hands, seated on a red and sharply limited base; these increased in number and size, and involved the backs of the hands chiefly as far as the wrist. The heat and pain of the eruption which, at its height, was limited to its face and neck, leaving the scalp intact, and also to the hands, was very distressing. The dyspnœa and delirium were severe, and were only quieted by opiates. Temperature was 101° Fah. On the third day, the eruption was at its height, and so much did the case appear like one of confluent small-pox that Dr. Janeway, the attending physician, suggested to the house physicians, Dr. Cutler and J. H. Frankenberg, to ask me to see it. I need here elaborate but little over Dr. Cutler's description. The face was very much swollen and disfigured, the eyes being closed. The integument was highly inflamed, much thickened and œdematous, and almost completely covered with large vesicles and bullæ. In the centre of the forehead these lesions were less numerous, and while the whole surface was hyperæmic, that on which individual vesicles and bullæ were seated, was thickened and markedly red. At the periphery of the eruption, below the clavicles and over the sternum, the redness and swelling of the skin ended abruptly as a general expanse, but there were a few outlying vesicles and bullæ surrounded by a deep-red and sharply marked areola. The history of the case, the clearly marked vesiculo-bullous character of the eruption, and absence of all shotty papules and pustules, its inception behind the ears, its limitation to the face, neck, and hands, clearly proved to my mind that it was not variola, while the striking features of its history proved it to be vesicular in character and allied in its nature to herpes. For want of a better name I diagnosticated the case as one of hydroa bulleux of Bazin. Though I had long been familiar with cases which accorded with the description given by Bazin of these vesiculo-bullous eruptions, I had never seen it attended with the acuteness and severity of the present case.<sup>1</sup> Bazin says that hydroa bulleux (pemphigus à petites bulles) is an arthritic affection, generally little known. It is

<sup>1</sup> "Leçons Théoriques et Cliniques sur les affect. de la peau." Paris, 1862.



sometimes preceded by loss of appetite and febrile movement. Its sole constant prodromic phenomenon is intense pruritus. The eruption manifests itself by bullæ, whose important character is their one quality of volume, rarely being larger than a pea. They are round, seated in an irregular manner, filled by a transparent fluid which rapidly becomes opaque, even yellowish. They are seated on a red base, with slight areola. They rupture and desiccate, and form yellowish crusts. The course of the disease is chronic, and attended with successive outbursts. It is more frequent in males than in females, occurring between the ages of twenty and forty years. Temperature has marked influence on its development. He has seen it mostly in spring-time. This affection was also considered in editorials in the *British Med. Journal*, May 14, 1870, which was then under the editorship of Mr. Jonathan Hutchinson, the description, which was based on personal observation, being similar to that of Bazin. At this date we were also familiar with the cases described by Wilson as herpes circinatus bullosus, pemphigus pruriginæux by Hardy, herpes gestationis by Milton, Bulkley, and others, the pemphigus aigu pruriginosus of Chausit, pemphigus composé of Devergie, pemphigus circinatus of Rayer, the herpes phlyctænodes of Gibert, the pemphigus of Klein, and the impetigo herpetiformis of Hebra. While I was convinced that the affection in the case now under consideration belonged to the great family of which these variously described cases were examples, I had recourse to Bazin's name as being the one most applicable and expressive. Yet in many particulars the history of my case differs from those of the other observers.

My friend, Dr. Duhring, has recently written a series of eleven able and exhaustive papers upon what have generally passed as anomalous cases of erythema, eczema, herpes, and pemphigus, and has done, it must be confessed, much good work in simplifying our knowledge and grouping into definite varieties cases which up to his time had been scattered unclassified in journals and text-books. All of these cases Duhring claims belong to one great family, to which he gives the name dermatitis herpetiformis, and of which he makes the following subdivisions: erythematous, vesicular, bullous, and pustular. In describing the different forms I think he makes his case out quite clearly, except as to the first or erythematous form, which he does not clearly and sharply diagnosticate from erythema multiforme.<sup>1</sup> In the light of Duhring's studies, the case I here consider would be called dermatitis herpetiformis bullosa, under which subdivision he groups all the cases I have mentioned as reported by Wilson, Hardy, Bazin, Milton, Charcot, Devergie, Rayer, Gi-

<sup>1</sup> "Relation of Herpes Gestationis and certain other forms of Disease to Dermatitis Herpetiformis," *Medical News*, Oct. 17, 1885. In this paper will be found a bibliography of all of Duhring's papers upon this subject.

bert, Hebra, and Klein, and still further the cases of B. Thompson, Liveing, Cottle, Gale, W. G. Smith, Jarisch, and Myer.

While I agree with Duhring in most of his clinical conclusions as to this vast family of disease, I am not prepared as yet to accept the application he gives it. In my judgment, his nomenclature requires further extended study, observation, and discussion. In his original paper,<sup>1</sup> Duhring, by implication rather than by direct statement, divides this protean disease into two varieties—mild and severe. He says: "In severe cases, prodromata are usually present for several days preceding the cutaneous outbreak, consisting of malaise, constipation, febrile disturbance, chilliness, heat, or alternate hot and cold sensations. Itching is also generally present for several days before any sign of efflorescence. Even in mild cases, slight systemic disorder may precede or exist with the outbreak. It will be noted that the descriptions of Bazin and Duhring of the affection under consideration do not clearly bring out such a marked and severe clinical picture as is shown by my case. Indeed, in looking through the literature very carefully, I have been unable to find a case precisely analogous. Under the title "*Ueber die Coincidenz von Erkrankungen der Haut und der grauen Achse des Rückenmarkes*," Jarisch<sup>2</sup> describes a case of which the following is a brief summary:

A married woman, aged 61 years, had in 1874 scattered bullæ upon the arms and face, which subsided spontaneously, the woman thereafter being troubled with redness of the parts affected. In 1877 she had inflammation of the lungs, and other minor troubles. In 1879 she had a copious, symmetrically distributed vesicular pustulous and bullous eruption, almost confined to the upper half of the body, including head and arms. The skin of the face and scalp was much swollen, very red, and covered with crusts and bullæ, grouped or isolated, and seated on a bluish base. On the arms and forearms were small papules and vesicles, and large and small bullæ. Upon the thorax severe dermatitis, with pustules, and sero-purulent elevations of the epidermis was present. A vast hemorrhagic bulla occupied the soles of the feet. The mucous membrane of the tongue was dry, and the mouth reddened, swollen, and in patches excoriated. Excepting swelling of the spleen, nothing abnormal was found on physical examination. The urine was albuminous and loaded with urates. The patient was weak and debilitated, and had marked fever. In a few days the eruption disappeared, leaving scales, crusts, and brownish pigmentation. In the following month new eruptions appeared, followed by bed-sores, abscess, and death. At the autopsy Bright's disease in the third stage, lobular pneumonia, and sclerosis of the gray columns of the cord from the third cervical to the eighth dorsal vertebræ. The skin affection began at the vertex, and ended about the umbilicus.

Duhring also quotes this case, and says that "it has sufficient points

<sup>1</sup> "Dermatitis Herpetiformis," *Journal of the American Medical Association*, August 30, 1884.

<sup>2</sup> *Vierteljahrs. für Derm. und Syphilis*, vol. 12, 1880, page 195.

in common with dermatitis to warrant its being classed here rather than elsewhere." Myer,<sup>1</sup> of Strassburg, reports the following case as one of a fatal pemphigus-like dermatitis, with changes in the nervous system. It was of a woman, sixty-five years old, previously healthy, in whom what was regarded as a diffuse eezema of the papular, vesicular, and rubrum varieties appeared without systemic reaction. In its fourth week large bullæ appeared on the buttocks and legs, together with grave symptoms of constitutional disturbance, which increased, and culminated in death, the disease having run its course in seven weeks. Duhring also quotes this case as one of dermatitis herpetiformis, and I thus briefly include it in this paper as being in some measure similar to mine. It is to be hoped that we shall hear from other observers who may have seen similar cases, so that later on our knowledge of this grave form of cutaneous affections may be more precise and extended.

I may here add that I saw with my friend, Dr. P. A. Morrow, at Charity Hospital, a case of which the clinical features, to my mind, pointed clearly to the diagnosis of hydroa bulleux of Bazin, or the dermatitis herpetiformis of Duhring.

---

## ON THE EXISTENCE OF "DERMATITIS HERPETIFORMIS" (OF DUHRING) AS A DISTINCT DISEASE.<sup>2</sup>

BY

L. DUNCAN BULKLEY, A.M., M.D.,

Physician to the New York Skin and Cancer Hospital, etc.

**A**MONG the many and varied lesions which may occur upon the skin in disease, curious and anomalous conditions are met with from time to time, rarely, it is true, which cannot with certainty be at once relegated to any one of the many well recognized maladies to which this great organ is subject; occasionally even a most patient and prolonged study of a case will not serve to give to it any one of the names ordinarily applied to diseases of the skin. Gradually peculiar cases, exhibiting similar features, previously un-noted, will be collected and analyzed, and from a study of them a description may be made which will serve to identify other instances of the same description, until at length such cases are recognized as belonging to a particular disease, with its name, pathology, etiology, and treatment. Thus it is that Dr. Duhring

<sup>1</sup> Archiv für Path. Anat. und Phys., Nov., 1883, page 185.

<sup>2</sup> Read before the New York Dermatological Society, February 23, 1886.

has endeavored to group together certain cases which had previously received various and uncertain names, under a single designation, "dermatitis herpetiformis," which he describes as a distinct disease, exhibiting many and different phases, still closely related to each other. How far he is warranted in the position taken remains to be seen, and forms the subject of our discussion this evening.

The following history of the patient exhibited at the last meeting of this Society illustrates and will serve to introduce the subject under consideration :

Alfred S., aged 24, a blacksmith, of muscular build and very intelligent, presented himself at my clinic at the New York Hospital, November 25, 1885, suffering from a chronic, universal, multiform, and intensely itching eruption, and gave the following history.

His parents, who were Irish, came to this country in 1850; a number of his mother's family and his cousins died of phthisis, and his father died of the same complaint; his mother is living and healthy. One brother, who died at twenty-four, was exceedingly nervous and irritable, having strange attacks, almost of temporary insanity. The patient has chewed tobacco excessively since he was nine years old, and also drank very heavily from eighteen to twenty years of age. When thirteen years old he began to masturbate, and practised this excessively until sixteen years of age, and probably later. He worked in a blacksmith shop from fifteen to seventeen, and then took up rag-carpet weaving for three years, after which he returned to blacksmithing.

The eruption first appeared in the summer, five years ago, when he was nineteen years of age, and has continued, almost without interruption—that is, with periods of improvement and relapse—up to the present time. It began during the period when he was working very hard, for nearly twelve hours a day, at carpet-weaving, and while he was chewing a paper of tobacco daily and drinking heavily, both in the daytime and during the evening. It may be mentioned that his work was done in a sitting posture, with both legs and arms actively engaged.

The first symptoms of his disease consisted of intense itching, with the sudden development of successive crops of what he described as "white pimples," apparently vesico-papules, present over much of the surface, except the head, which has been involved only within the past year. During the hot weather, when the eruption first appeared, the patient perspired profusely across the chest, and affirms that his undershirt was always stained a peculiar greenish color by the perspiration; this phenomenon he had never observed before or since.

The eruption has generally been somewhat worse in the summer time. While it has affected at times most of the surface of the body and limbs, it has appeared most profusely upon the buttocks and the lower abdomen and groins, extending even upon the penis. The patient has himself remarked the multiform character of the eruption, it often changing its form to boils and abscesses, as he says, and at other times presenting ulcerations, the result of scratched lesions. The itching has always been most intense during the day, and to relieve this he at one time took considerable liquor, which seemed to have a temporary benumbing effect; beer was always found to have a worse after-effect than spirits. He had



Journal of Cutaneous  
and  
Venereal Diseases,  
April, 1886.



Dr. Taylor's Case of Hydroa Bulleux.



tried the greatest variety of treatment, but all with only temporary, if any, benefit.

When first seen (November 25, 1885), both forearms and elbows were covered with small, shining papules, a few of them showing vesiculation, from which a drop of clear serum could be squeezed. The thighs were thickly sprinkled with reddish blotches of various sizes, some over half an inch in diameter, many of them not elevated above the skin, and representing only pigmented stains, while others were more or less elevated and represented the remains of the inflammatory bases and areolæ of former pustules. The loins and buttocks were also the seat of eruption, presenting flat, adherent crusts on slightly inflammatory bases. There were also remains of eruption on the back, and some few lesions on the lower legs, and some superficial scars of various sizes and shapes, slightly depressed and sharply defined, scattered over various portions. His general condition was good, he was well nourished, and the flesh firm; he was habitually constipated. He was given a laxative pill, an alkaline tonic, and an antipruritic lotion.

December 2. The itching has been slightly allayed, but the eruption is worse. Crops of superficial pustules have appeared over the limbs, and also in the lumbar region; inguinal adenopathy exists.

December 9. Over the upper part of the right scapula a patch of eruption has appeared, strongly suggestive of herpes zoster. The group is irregular in shape, an inch and one-quarter in diameter, and composed of papulo-vesicles, with a few much smaller clusters and isolated papules. A somewhat similar eruption has also appeared upon the scalp. The lesions are attended with much itching. The patient was directed to cease the use of tobacco, which he was quite willing to do, as he had become much demoralized by his disease. He was given an acid, iron, and magnesia mixture, with the addition of strychnia.

December 23. Fresh eruption has again occurred, now in the form of pustules, upon the arms and in the axillæ, and upon the legs.

January 2, 1886. Again a fresh outbreak, this time mainly on the calves, in the form of large, ecthyma-like pustules, in moderate number, and evenly distributed.

January 20. The patient has still fresh lesions developing upon the loins, buttocks, thighs, and elsewhere. They are now in the form of large, flat, rather flabby vesicles or bullæ, containing a whitish, turbid or purulent serum; these are evidently the lesions which gave rise to the flattened, adherent crusts already mentioned.

Since the last date the patient has continued under observation and treatment, with no material change in his condition, except the continued production of the lesions from time to time, together with great itching. The last phase of the eruption was in patches, over the scapulæ, mainly of erythematous appearance, varying in size from one-half to one and a half inches in diameter, with grouped vesico-papules upon them.

Did time permit I should like to detail some other somewhat similar cases, more or less illustrative of our subject, but must now content myself with this for my text.

The question now arises, What name should be given to the disease in such a case, and where should it be classed? It presented many lesions—

papules, vesicles, blebs, pustules, and erythematous patches—was accompanied with great itching and persisted for five years, apparently yielding to no treatment, but exhibiting exacerbations with marvellous facility. The vesicular and bullous lesions might place it with eczema, herpes, or pemphigus—but no one familiar with the ordinary types of these affections would so consider it. It did not present the history or phases of erythema multiforme, or urticaria bullosa—where, then, shall it be classed? Evidently there is room for a proper and sufficient designation for these cases, the like of which are occasionally met with and have been reported from time to time under many different names.

For a number of years attention has been called, by many observers, to the varieties of appearance presented by certain vesicular and bullous eruptions, and the names which have been applied to them in literature are so many that their simple recital would occupy much time, and the record of them would probably be of no profit. And yet we are to-day far from having a clear and definite understanding and agreement as to the nature, course, and pathology of this class of affections. The majority of text-books mention but three names of principal diseases where serum occurs in vesicles or blebs, namely, eczema, herpes, and pemphigus; others add hydroa and pompholyx, together with erythema multiforme and vesicating urticaria, while some authors record single names, not accepted by other observers. The many varieties of herpes which have been described, and the long discussions in regard to pemphigus, serve to illustrate the difficulty of the subject and the uncertainty still present.

Within the last two or three years, Dr. Duhring has repeatedly called the attention of the profession to the existence of what he believes to be a distinct disease of the skin which had not been before fully described, and which, as will be seen, is made to include such cases as that detailed, and also a number of other eruptions which have hitherto been reported under very different titles; this disease he describes under the name of “dermatitis herpetiformis.” If it can be clearly established that such an affection really exists, embracing the variety of lesions which he has attributed to it, a step in advance will be gained, and a name be given to quite a class of cases which have hitherto been considered anomalous, or have received various designations by different writers. As yet, however, it can hardly be claimed that other workers in dermatology have accepted this disease as an entity, or have largely identified it in practice, certainly not by this name. Every claim of this kind should therefore be criticised by other observers in the same line of study and practice, and be substantiated or refuted, as the case may be.

In order for us to intelligently discuss the subject this evening, I shall, as briefly as possible, condense the description of the main features



of the disease as given by Dr. Duhring,<sup>1</sup> and in doing this I shall, as far as possible, adhere to the language of the author.

According to Dr. Duhring, dermatitis herpetiformis is a well-defined disease, characterized by a variety of symptoms, which, although they appear dissimilar, and perhaps in no way related at first sight, will sooner or later be found to be but different expressions of one process. It is one of the rarer cutaneous manifestations, only one variety of which has been heretofore carefully described, namely, the pustular, by Hebra, under the name of impetigo herpetiformis. In severe cases the disease is ushered in with malaise, shivering, etc. Itching or burning is early pronounced, followed in the course of from twelve to forty-eight hours by more or less eruption, consisting of erythematous, maculo-papular, papular, tubercular, vesico-papular, vesicular, vesico-bullous, bullous, or pustular lesions, as a rule all having peculiarities which distinguish them from the manifestations characterizing other well-known diseases.

The erythematous lesions resemble erythema multiforme and urticaria, being most like the former, but less raised. The vesico-papules are similar to those of erythema multiforme or in the early stages of herpes iris, and where numerous and close together, and occurring upon thickened, pigmented skin, may resemble the first stages of confluent variola.

The vesicular lesions may vary in size from a pin-head to a pea; are flat or slightly raised, broad, angular, or irregular in outline; of a pale yellow, tensely distended, glistening, and without areolæ, unless closely grouped. The blebs vary in size from a pea to a pigeon's egg, or even a hen's egg, raised as in pemphigus, and may have opalescent, cloudy, hemorrhagic, or even pustular contents.

The pustules begin as small, flat, pin-head sized, whitish lesions which grow, as a rule, in from two to six days to the size of a small pea, when they are surrounded by a deep-red, "angry looking," more or less raised areola. Sometimes two or three small pustules appear as a little cluster, as they run together, forming a large pustule. About the time the lesion is at its height, one, two, four, or more new, small, flat pustular points or distinct papules begin to appear in the form of a ring, or as a segment of a circle, immediately around the original lesion, which by this time is somewhat crusted. As these increase in size they are absorbed into the first pustules, the whole being covered with a yellowish, greenish, or brownish, flat, adherent crust. New small pustules may also continue to form around this lesion, as before, or the process may be arrested. The number of pustules varies from half a dozen, scattered, even to hundreds, some about the size of a pin-head or of a pea, others as large as a quarter

<sup>1</sup> Journal of the American Medical Association, August 30, 1884, and American Jour. Med. Sci., October, 1884.

dollar. When they are in close proximity and have run together, large patches may form.

In further description of the disease, Dr. Duhring states that multiformity is the striking feature presented, where cases remain under observation for a number of years. An attack beginning as an erythema may pass rapidly into the vesicular or bullous variety, to be succeeded in a few weeks by the pustular form, and this again by the vesicular or bullous variety, followed perhaps by the pustular for a second time, all these changes or varieties of the disease appearing, it may be, in the course of a month or a year. Also many different lesions may occur at the same time, even pustules and blebs being observed almost contiguous. The eruption may remain of one type, as vesicular, for some time, and then change character, assuming some of the other forms. The tendency is to be vesicular and bullous, the erythematous and pustular manifestations being rarer.

The general character of the eruption is regarded as herpetic because the lesions incline to group, or to appear in small or large patches and to coalesce, and also because in the erythematous and pustular varieties there is a marked tendency to creep or spread peripherally. But Dr. Duhring also states that, in the vesicular and bullous varieties, there is less tendency to group, and the vesicles and blebs may be disseminated at one time, and grouped at another. The irregular, angular, or stellate outlines of vesicles and blebs is also regarded as strongly suggestive of herpes.

The disease usually runs a chronic course, extending over years, even five, ten, or fifteen, the patient suffering more or less continuously, sometimes with periods of months of comparative or entire freedom from the eruption. The disease attacks both sexes, and usually in early or middle adult life. It occurs in single, as well as in married women, though more frequently attacking the latter, especially during pregnancy and in the parturient state. It is without question a neurotic disease, in some cases being manifestly under the control of the nervous system.

In order to put the salient features of the disease in a few words, I will, further, quote the conclusions given by Duhring:

1. The existence is shown of a distinct, clearly defined, rare, serious, herpetic disease of the skin, manifesting itself usually in successive outbreaks, characterized by more or less systemic disturbance, a variety of primary and secondary lesions, and severe itching and burning.

2. The disease is capable of appearing in many forms, having a tendency to run into one another, irregularly; the principal varieties being the erythematous, vesicular, bullous, and pustular, which may occur singly, or together in various combinations.

3. The disease is protean in character, and is remarkable for its multiformity.

4. The pustular variety is the same manifestation as that described by Hebra under the name "impetigo herpetiformis."

5. The term "dermatitis herpetiformis" is sufficiently comprehensive and appropriate to include all varieties of the disease.

6. It may occur in both sexes, and in women independent of pregnancy.

7. It usually pursues a chronic, variable course, lasting years, and is very rebellious to treatment.

In one of his later communications, he claims that many similar forms of eruption, reported with various titles, by different observers, are all merely instances of one process, namely, dermatitis herpetiformis as he has defined it. Thus, he mentions herpes circinatus bullosus, pemphigus prurigneus, herpes gestationis, pemphigus circinatus, herpes phlyctænodes, pemphigus aigu prurigneus, certain cases of hydroa, and other eruptions.<sup>1</sup>

Such being the description, in brief, given by Dr. Duhring, of what he considers a distinct disease of the skin, capable of demonstration, it remains for us to consider the grounds for this position, and the objections to the same.

The first point which must strike every one is that emphasized by the author, namely, the multiform character of the lesions and the variety of manifestations, which are included as belonging to one disease. But this need by no means be considered a valid objection to its acceptance, for we all recognize at once the very great variety of appearances which may be presented by eczema and scabies, and also those which have been described under erythema multiforme, and also the marvellous variety of cutaneous phenomena excited by syphilis; so that, provided the lesions can be shown to be related to one another, or to depend upon the same cause, or to have the same pathology, their multiformity of appearance need be no valid objection against their constituting a single and well-defined disease. Dr. Duhring states that he has watched some of these cases over a period of years, and that his description is written from a prolonged study of some sixteen or seventeen cases, a number of which he has given in detail<sup>2</sup> in various publications.

But more serious questions arise in regard to the adoption of "der-

<sup>1</sup> The Medical News, Philadelphia, November 22, 1884, and October 17, 1885.

<sup>2</sup> Philadelphia Medical Times, July 12, 1884. The Medical News, Philadelphia, July 19, 1884. The New York Medical Journal, July 19, 1884. JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, New York, August, 1884. The New York Medical Journal, November 15, 1884. The Medical News, Philadelphia, March 7, 1885. Amer. Jour. Med. Sci., January, 1885.

matitis herpetiformis" as a distinct disease with the name and description already given, which may be considered under three heads.

1. Have we here to do with a separate disease, possessing uniform characteristics and causes, upon which a sound pathology and treatment can be based?

2. Do we advance any nearer a right understanding of the nature, cause, and cure of these cases, many of which have been classed with other affections, by grouping them together under a single name?

3. Does this name, dermatitis herpetiformis, best express the nature and character of the disease?

In answer to the first question, I would say that the more I see of these cases of multiform, inflammatory eruption, with itching, the more impressed I am that we are as yet unacquainted with their nature and cause, and the more certain I feel that there must be some grave nervous disorder as a prime factor in their etiology; probably some changes will be found in the nervous centres or trunks, as in herpes zoster and pemphigus. Whether the cases all own the same, or even a similar cause, cannot by any means be determined, much more study, both in the direction of clinical record and pathological research, is necessary before their entire history can be written.

I believe, however, that such cases as that I have detailed, and some of those reported by Dr. Duhring and others, belong to a class of disease which has not hitherto been recognized in our text-books, and I quite agree in grouping them together under one designation, and in recognizing them hereafter as representing a particular disease; although I think that later we shall find it desirable to isolate individual instances exhibiting peculiar elements of causation. Whether we are, however, correct in creating a single disease out of the varied pathological changes thus far mentioned, irrespective of their varied causation, appears to be as yet somewhat problematical.

Closely connected with this is our second question, whether we advance any nearer a right understanding of the nature, cause, and cure of these cases by thus grouping them together under a single name. As we have seen, Dr. Duhring claims that quite a number of affections, hitherto regarded as distinct, and described under different names, such as herpes gestationis, pemphigus pruriginosus, hydroa, and the like, are all to be regarded as but phases of this complaint, dermatitis herpetiformis, asserting most positively that the impetigo herpetiformis of Hebra, which was always observed in connection with the parturient state, and was almost invariably fatal, is certainly only the pustular variety of this one great disease, which he never observed to be fatal. Until much more light is thrown on the etiology and pathology of all these affections, it would seem that we lose rather than gain by considering them together,



for the conditions under which they have been observed are so entirely dissimilar. It is difficult from Dr. Duhring's statements to discover just how far he would go in claiming cases which others would recognize as erythema multiforme, urticaria bullosa, herpes iris, hydroa, pemphigus, or even eczema, to be illustrations of the different aspects of dermatitis herpetiformis. It would, of course, be very convenient to have one grand disease into which anomalous and polymorphous eruptions could be thrown, but the very serious question arises whether, by thus contenting ourselves with a name, we are not in danger of neglecting a closer study of the etiology and pathology of these cases, which may lead to more intelligent, and consequently to a more successful treatment.

I think Dr. Duhring has attempted to include too much under his one disease, and thereby weakens its clinical and pathological standing. I am not willing to concede that herpes gestationis, as I have observed and described it, has any connection with the disease under consideration, and certainly cannot agree in placing Hebra's impetigo herpetiformis in this position. Further study would, I am sure, result in showing that the same could be said of other forms of eruption which he seeks to group with the disease under consideration.

Our third question is also an important one: Does this name, dermatitis herpetiformis, best express the nature or character of the disease, if, indeed, there is clinical or other evidence sufficient to warrant the introduction of a new name to indicate certain of these cases which can be grouped together?

The object of nomenclature in disease has long been recognized to be to so name an affection that an intimation is thereby furnished in regard to its clinical phenomena or its pathological elements. Dermatitis is a very indefinite term, expressing only the inflammatory element in the skin, and could be applied to a score of eruptions; if used in the present case it might well be modified by some expletive which indicated more of the character of the disease than the word herpetiformis appears to furnish. From a careful study of all of Dr. Duhring's writings on the subject, and from observation of a number of similar cases, I cannot agree that this name is warranted by the "herpetic" elements occasionally found, whatever may be indicated by that term; a preferable addition would be "multiformis," or even "neuritica," to express the well-recognized nervous element in most, if not all the cases.

The term which I would most prefer would be "dermatitis pruriginosa," as expressing the inflammatory element, and also the single, constant element of itching prominent in all the cases reported.

In conclusion, I may sum up the matter, as it now appears, as follows:

1. Cases occur from time to time in practice where the lesions on the

skin are such, and the disease pursues such a course, that it cannot be located as any one of the well recognized diseases of the skin.

2. It is probable that with advancing observation and knowledge many new diseases of the skin may be isolated and described by the collection of instances of eruption now regarded as anomalous.

3. Some of these peculiar cases exhibit many aspects and phases, and may present a great multiformity of lesions at once or in succession.

4. While we cannot accept the "dermatitis herpetiformis" of Duhring as a distinct disease, including all the forms and varieties of eruption he claims for it, there is undoubtedly sufficient ground for grouping together, under a single designation, some of these cases presenting itching or burning with a multiform, recurring eruption, exhibiting great rebelliousness to treatment.

5. The so-called "herpetic" element in these cases is so slightly marked, and of such an indefinite character, that the term *dermatitis pruriginosa* would seem to express more correctly the clinical or pathological element of the disease than the one chosen.

6. There is a danger lest in accepting a general term to indicate many of these polymorphous, itching eruptions, we lose sight of the peculiar characters and etiological elements in each, and so fail to grasp them from a practical and therapeutical stand point.

4 EAST 37TH STREET.

---

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

161ST REGULAR MEETING, FEBRUARY 23, 1886.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. BULKLEY opened the discussion of Dr. Taylor's paper on

THE HYDROA BULLEUX OF BAZIN AND DERMATITIS HERPETIFORMIS OF DUHRING,<sup>1</sup> read at the last meeting.

DR. WEISSE said that he had seen three or four cases presenting multiple lesions similar to the cases described by Duhring, some being herpetic, others bullous. He thought that a great deal of time was lost in attempting to give a definite name to skin diseases. He believed that more practical conclusions could be arrived at if we look upon the lesions presenting themselves simply as symptoms, and then striving to ascertain the causes thereof. As to ascribing a neurotic cause to skin lesions, it seemed to him that that was done for want of other data to work on. In late years, he always, in every case of skin disease, had given particular attention to the condition of the alimentary canal, and endeavored to arrest disordered secretions. He was not prepared to say whether the name dermatitis herpetiformis was a proper one.

<sup>1</sup> Page 111, present number.

DR. BRONSON had seen a number of cases which he believed would be regarded by Duhring as instances of dermatitis herpetiformis. He could not avoid the impression that under this term a complication of different affections had been included. He was disposed to admit, however, that it embraced a special affection which was always present, and which was the essential factor in all of the cases. What the precise nature of this special affection was, was as yet undetermined. The name which Duhring had given his disease would imply, perhaps, that it was allied to herpes. But in B.'s opinion the disease was much more nearly related to pemphigus than herpes. From a study of Duhring's and his own cases, he had almost always found that the initial form of efflorescence was a simple vesicle unattended by areola or marked signs of inflammation. Such a vesicle was a mark of pemphigus. It was only subsequent that various inflammatory manifestations were superadded, such as erythema, pustulation, and the like, and these the speaker believed to be simply evidences of common irritation, the result of the itching and scratching which were features of dermatitis herpetiformis. Long-continued irritation of the skin usually led to polymorphous lesions, as seen in pediculosis, for example, or in that of multiform affection which the speaker had termed (having regard to its most prominent manifestation) the urticaria of immigrants. Toxic exanthems were similarly characterized. Hence he was of the opinion that while, for the present, the name and the description of the disease given by Duhring served well enough for purposes of identification, there was in reality included within the term a complex of affections, in which, however, there was invariably present a special morbid factor that belonged to one of the types of vesicular disease, and rather to the type of pemphigus than to that of herpes.

DR. MORROW remarked that he had no well-defined views as to the nature and proper nomenclature of the disease under discussion. If its neurotic origin and nature were clearly made out, he should prefer the term tropho-neurotic dermatitis. He thought the qualifying adjective, "herpetiformis," misleading and objectionable, since it does not appear to form an essential element in all cases. Certainly in three cases under the speaker's observation, which corresponded in their general features with the cases described by Duhring, viz., in the multiformity of the eruptive elements, their chronicity and intensely pruriginous character, the herpetic tendency was not a prominent feature, if, indeed, it could be said to exist.

The speaker thought that Dr. Duhring had been too ambitious in attempting to group together a number of vesicular diseases, the etiological connection of which had been by no means proven, and which may, perhaps, be in no way related, except by the accident of a common eruptive element. He had included in this group the hydroa of Bazin, the arthritic affinities of which had been distinctly asserted by the French school, and also the impetigo herpetiformis of Hebra, which was entirely different in its origin, course, and tendency.

Before a name is given to a new disease, its etiology and nature should be definitely determined.

DR. ALLEN had met with a number of cases that agreed with the description of dermatitis herpetiformis as given by Dr. Duhring, but he did not like the term; he would prefer the name dermatitis multiforme. He had seen the case referred to by Dr. Bulkley, and in that case the herpetic element was absent, and the pustular predominated.

DR. SHERWELL remarked that he had listened with great interest to the reading of Dr. Duhring's original paper. During the recital of Hebra's cases of impetigo herpetiformis, he had been led to wonder if that celebrated professor had ever been much in contact with septicæmic or pyæmic cases, as they, by history and symptoms, correspond very closely to these anomalous eruptions. The marked fatality was also in favor of that conclusion, and in the discussion following the paper at that time, he had made the same criticism, and offered as a substitute, for this form at least, the term dermatitis necrogenica. He thought that the same applied, perhaps, in less degree to herpes gestationis, and believes the conditions due probably to embolism, peripheral in character, or metastatic, in cases of salpingitis or septic matter from broken-down pus deposits in the uterus, or appendages, or surroundings.

He had observed a case, occurring in less than fourteen days after hearing Dr. Duhring's paper, in his service at the Brooklyn Hospital—a boy with diphtheria, in whom a typical eruption of the kind described had appeared late in the dis-



ease, grouped bullæ, with pruritus marked over the body and extremities. The child eventually recovered.

He thought, with most of the members present, that dermatology would not be ready to accept the title, it being one that covered too much ground, and that some of the cases described under this heading might be better classed as hydroa and anomalous forms of pemphigus. He did think that if any generic name were insisted on, it should be a negative one, as, for example, dermatitis *multiforme*.

DR. ROBINSON did not believe that it is advisable, in selecting a name for a given disease, to choose one which suggests a certain pathology or etiology as our views of the latter may, and are likely to change, in which case the name becomes misleading. He therefore objects to the term dermatitis herpetiformis as applied by Dr. Duhring, even if it was clear that the lesions described under this name are symptoms of the same condition or state, and prefers one which carries no meaning in itself to the student's mind. Neither does he think that there is an advantage in striving to group under one name lesions, apparently at least, so different from each other in their etiology and pathology; and believes that in dermatology, as in other departments of medicine, the number of names will increase with our increasing knowledge of the subject. He believes that, taking into consideration the forms of the lesion, the course of the disease, and the results of treatment in the different cases, Dr. Duhring has grouped together widely different cases of cutaneous eruptions, some of which are much less closely related to each other than to other already well-known diseases. Many of the mild cases are certainly very closely related to pemphigus, as was shown in his own patient, and which yielded readily to large doses of arsenic at each attack of the disease. The same objection applies to the names suggested by Dr. Bulkley as to dermatitis herpetiformis.

DR. PIFFARD did not believe that the various cases described by Duhring as dermatitis herpetiformis were all examples of the same disease, or that they even belonged to the same group. He was unwilling to put any of them in the class of neurotic affections, until it was shown that they depended on some definite, pre-existing nerve lesion. In zoster or some forms of leprosy, nerve lesions had been demonstrated; not so in the so-called dermatitis herpetiformis and many other affections which some claim to be of nervous origin. He thought that the name employed by Dr. Duhring about as bad a one as he could have selected, inasmuch as pure vesicle formation was by no means a prominent feature of many of the cases; on the other hand, zoster, which is an inflammation with vesicle-formation, is not included. Two years ago he had proposed the term *dermatitis multiforme* as a provisional appellation under which to include these obscure and perhaps unrelated affections, it being far better to use a name that involves no idea of nature or relationship until our knowledge is a little more definite on these points.

DR. TAYLOR said that the discussion had extended far beyond what he expected it would. He thought that Dr. Duhring had grouped too many different varieties of lesion under one name. He agreed with Dr. Robinson that it would be better to give a vague name to a disease when the pathology was not known. The fatal point with Dr. Duhring was that, in describing his cases, he argued on the lines of dermatology and not on those of general medicine. His (Dr. Taylor's) object in reporting the case was to have others carefully studied, so that we might arrive at some definite conclusions.

DR. BULKLEY, in concluding the discussion, said that, if time had permitted, he could have described other cases of so-called dermatitis herpetiformis, and spoke of one in particular occurring in a married woman about 35 years old, in whom crops of eruption, vesicular, bullar, pustular, etc., made their appearance, even when she was under the most careful treatment. At times she would apparently get well, but soon again crops of vesico-pustules would appear without any apparent cause. She had been variously treated, and among other things arsenic in large doses had been given.

DR. PIFFARD exhibited an

#### ELECTRIC LIGHT FOR SKIN EXAMINATIONS.

The apparatus consisted of a small six-cell portable battery made by the Galvano-Faradic Company, and capable of lighting a four-candle light, and keeping up a steady light for an hour or more.



## Reviews.

---

CUTANEOUS MEMORANDA. By HENRY G. PIFFARD, A.M., M.D. William Wood & Co. Third Edition, 1885, pp. 268.

We are glad to welcome this little book with the imprint "Third Edition," upon its title page. Its merits are so well known that we need not say much more in its praise; and the fact that a new edition has been so soon called for, attests the value that the student and practitioner put upon it.

This edition differs from the former ones, when its title was "Cutaneous and Venereal Memoranda," in that the chapters upon venereal diseases have been omitted. This omission is justified on account of the recent publication in the same series of a most concise and complete manual upon the Venereal Diseases, by Dr. P. A. Morrow. It has further been, to a large extent, rewritten and rearranged, the space given to treatment has been very much increased, and nine woodcuts, illustrative of different diseases, have been added. We would lay special emphasis upon the fact that in this little book we get the result of the author's wide personal experience, and the expression of his independent judgment, not a *resumé* of the ideas of other authors as to etiology and treatment. This makes it peculiarly valuable to the student or to the practitioner who is not versed in dermatology, as it is a great thing to have the guidance of one master when called upon to treat a patient, and not to be compelled to choose between a great number of plans of treatment by many men. It is with pleasure that we commend the book, and express the wish that soon a fourth edition will be called for.

DISEASES OF THE URINARY AND MALE SEXUAL ORGANS. By WILLIAM J. BELFIELD, M.D. New York: Wm. Wood & Co., 1884.

DR. BELFIELD is favorably known as the author of the Cartwright Lectures for 1883 on the "Relation of Micro-Organisms to Disease." Those who are acquainted with the minute and painstaking investigations which were the basis of those admirable lectures will expect to find much valuable information in any subsequent work of the author. In his preface Dr. Belfield says that "it was the author's hope to present a *resumé* of current knowledge of the topics herein discussed, with comments suggested by personal observation and experience," but that, owing to various reasons, he is unable to present a thorough treatise, but prefers to submit the original draft of the book. This is unfortunate, since there is evidence in what is presented that, had the author carried out his original design, he could have produced a very useful book. As it is, the treatise is fragmentary and unsystematic. We think that, while Dr. Belfield, in the main, is right in saying that a lack of care and thoroughness in the investigations of patients is responsible for many failures in the management of urinary and genital disorders, such lack of care in diagnosis is not as widespread as by implication he would have us think. While in America we may not indulge in the cumbersome and oftentimes over-elaborated methods of investigation employed by the German school in which Dr. Belfield was educated, in general in our treatises on these subjects all necessary information is given in a simple and practical manner.

Dr. Belfield's work is divided into two parts; the one treating of the urinary organs, and the other on diseases of the male sexual organs. In the first chapter of Part first, upon anatomical and physiological considerations, we find a fair résumé of our knowledge of the anatomy and physiology of the kidney and its pelvis, the ureters, the bladder, prostate, and urethra, to which is appended a section on general symptomatology, which might have been made more valuable if more concisely written and so much space had not been taken for cases. In the second chapter, much valuable information upon methods of examination is given in a more compact and satisfactory manner. The third chapter, upon the use of the sound and catheter, contains nothing new. We then come abruptly upon a chapter on urethral fever without previous ones detailing the operations to which this grave accident is often a complication. In the main, this chapter is good. Then follow chapters on the precautions to be observed before catheterism, digital examination of the bladder, endoscopy, and on the determination of the urethral calibre which, though good, would have been more valuable if more systematic and tersely written. Then follow chapters on the physiology and pathology of the urine, albuminura, glycosuria, pigments, the daily amount of urine, urinary sediments, and the clinical examination of the urine, which seem out of place in such a treatise, and which are not remarkable for any striking excellence. They are good in their way, but would have been more valuable if sharply and concisely written. The chapter on diseases of the kidney is the most systematic in the book, and may be read with profit, while that on diseases of the bladder bears inherent evidence that the author writes of what he has seen in the practice of others rather than in his own.

The second portion of the book, devoted to diseases of the male sexual organs, is embraced in about thirty pages, in which prostatic disorders, functional disorders, seminal incontinence, impotence, and sterility are discussed in a discursive manner, and lack that clear conciseness of statement which is especially necessary in handling these subjects. Though we have thus spoken of the shortcomings of the book, which in the main the author admits, we must add that it contains much valuable information, and may yet form the basis upon which, with further extended experience, the author may found an exceedingly valuable treatise.

---

## Selections.

---

### ADULTERATION OF CUBEBS.

THE employment of cubebs as a remedy in gonorrhœa is so extensive that any adulteration of the drug is to be deplored.

At a meeting of the Society of Medicine of Nantes, Jan. 8, 1885, Dr. Menier reported that, in continuing his investigations into purity of drugs dispensed in Nantes, he had in a somewhat accidental way discovered that pure cubebs are adulterated with another form of cubebs whose exact nature he has not yet been able to determine positively, but which he believes to be the *Piper Crassipes*.

Entering his laboratory one day, where a student was pulverizing some cubebs, he found the air laden with the odor of laurel and nutmeg; odors entirely different from that of cubebs. He examined the cubebs at hand, and a number of

specimens obtained from druggists, and found in all berries differing from real cubebs, *Piper longum*. The false cubeb berries had a more grayish aspect, their taste differed from the real, and their odor was strong and camphor-like. When treated with a few drops of concentrated sulphuric acid, real cubebs give a carmine color. This test applied to the suspected cubebs gave a yellowish-brown color, and this is the reaction color said to be characteristic of the *Piper Crassipes*.

The results obtained by Dr. Menier were verified by Dr. Marais, who believes that nowhere in France can pure cubebs be found.—*Gazette Médicale de Nantes*, No. 3, 1886.

### RARE MALFORMATION OF THE URETHRA.

DR. POISSON related a rare case of malformation of the urethra to the Société Anatomique de Nantes at its December meeting, 1885. The patient was a boy who, at birth, had a perforated and permeable meatus; but it was noticed that in urination a pouch formed beneath the meatus, and was only emptied by pressure. Later, a small abscess formed in the region of this pouch, and upon opening formed a fistula through which the urine flowed, ceasing at the same time to flow from the meatus.

It was attempted to pass a small sound through the meatus, but it penetrated only to the perineo-bulbar region. When introduced through the fistula, the sound could be passed into the bladder. It was thought that there existed in this case a bifurcation of the urethra, one of the branches, the superior, tending to become obliterated, while the inferior remained permeable.

Dr. Malherbe, who had observed the child with Dr. Poisson, thought that there existed in this case what is seen in cases of hypospadias, that is to say, two canals, one communicating with the bladder, the other with the external opening.—*Gaz. Méd. de Nantes*, No. 3, 1886.

### THE ABORTIVE TREATMENT OF URETHRITIS.

URETHRITIS has been treated successfully by Dr. Munnich by having his patients drink large quantities of water or milk, emptying the bladder every two hours during the day, and at least once during the night, followed by the injection of a 3% solution of resorcin.

In four or five days after the discharge has diminished, he injects three or four times during the day and once during the night, and then gradually diminishes the frequency of the injections until the discharge ceases, which usually occurs in about two weeks. It is desirable to continue the injections for some time after the cessation of the discharge.

Letzel has cured fifty-six cases by this method, and adds his testimony as to its benefit. He begins with a two-per-cent solution, and later on uses a three-per-cent solution, as he finds the stronger solution too stimulating at first. He calls attention to the fact that the preparation of resorcin is not always the same. Good chemically pure resorcin is white, and when dissolved in distilled water forms a perfectly clear solution; if the solution be colored, it will produce irritation of the mucous membrane of the urethra.—*St. Petersburger Med. Wochenschrift*, No. 44, 1885.

## INTERNAL ADMINISTRATION OF CHRYSAROBIN IN ECZEMA AND IMPETIGO OF CHILDREN.

IN the *Annal. de Derm. et de Syph.* for 1884, Dr. Stocquart first advocated his treatment of a great variety of skin diseases by the internal administration of chrysarobin. Dr. S. now states that chrysarobin is not to be used in every form of eczema, and that it is not the universal panacea for skin diseases that his early experiences with it had tempted him to believe. While further observation is necessary before it can be definitely settled in what classes of disease the drug is indicated, he has found it of decided benefit in eczema and impetigo of children, and here publishes notes on eight cases, four of each disease, in which a cure resulted in from two to nineteen days after beginning its use. The dose used was from 0.005 to 0.04 in twenty-four hours. In all cases, it caused a fading of the redness and a lessening of the secretion; therefor, the doctor regards it as acting by causing a contraction of the blood-vessels and a lessening of the blood supply to the part.—*Monatshft. f. prakt. Dermat.*, January, 1886.

## IODOFORM IN VENERAL DISEASES.

A REVIEW of the literature of the subject, joined to his own experience with iodoform in venereal diseases, has led Dr. Bockhart to formulate the following aphorisms in regard to it:

Iodoform is not of the least use in the treatment of gonorrhœal inflammation.

Ulcers and erosions of the vaginal portion of the uterus, the result of cervical gonorrhœa, are amenable to iodoform.

Iodoform should be regarded as a specific against the virus of the soft chancre, and is the best, surest, and most rapid means of treating all sorts of soft chancres.

Suppurating inguinal buboes are best and surest treated with iodoform, especially after the method of Petersen.

In syphilis, the internal use of iodoform is far less satisfactory in its results than that of iodide of potassium, and is most useful in syphilitic neuralgia.

Iodoform is of use against the ulcerated gumma of syphilis, alone of all its lesions, and against this it seems to exercise a specific action.—*Monatshft. f. prakt. Dermat.*, January, 1886.

## TREATMENT OF ANGIOMA.

DR. R. CAMPANA has found multiple punctures followed by the application of lint and dried perchloride of iron of great service in the treatment of small capillary angiomata. For twenty-four hours after the operation, there is a superficial reaction in the form of an erythema, but by the second or third day the part treated becomes pale. If one operation is not sufficient, it is to be repeated.

In one case of angioma cavernosum upon the face of a child, he effected a cure in one month by the galvano-cautery. In order to prevent hemorrhage in the first operation, he made use of a perforated metal plate, shaped exactly to the angioma. By this, he was able, not only to prevent hemorrhage, but the cauterizations were made at regular distances, and a reduction in the size of the tumor was obtained. In the second operation, the plate was not used, and the cautery was more freely employed to destroy the little islands of angiomatous tissue. There was little hemorrhage, the vascularity having been much lessened by the first operation.—*La Salute*, 1885, Nos. ix. and x.



## THE LOCAL TREATMENT OF THE CUTANEOUS LESIONS OF SYPHILIS.

OCCLOSIVE dressing with Vigo's plaster, made according to the rules laid down by its originator, Chassaignac, cuts short the length of treatment, and is curative even when general treatment is omitted.

The therapy of the local accidents of syphilis varies according to the nature of the lesion, and the age and constitution of the individual.

Many cases of the iritis have been cured by the simple procedure of occlusion of the lids and the inunction of mercurial ointment over the brow.

Secondary and tertiary lesions are beneficially affected by local dressings, no matter what preparations be employed. We see physicians obtain good results with iodoform (Féréol); others with powdered subcarbonate of iron (Vidal); Labarraque's solution (Fournier); nitrate of silver and acid nitrate of mercury (Mauriac).—N. DUBROMELLE, *Thèse de Paris*, 1885.

## THERAPEUTICAL USE OF LANOLIN.

THIS newly-introduced base for ointments, much praised on account of its penetrating power, has been tried by Dr. Lassar in his clinics. He has found that it penetrates the skin in a few moments when rubbed lightly in, the skin feeling somewhat turgid afterwards, but its surface almost entirely dry. After trying it upon four hundred patients, he finds that it has no irritating or other bad effect on the skin; but, on the contrary, even with an inflamed skin it acts advantageously. It was found very useful in eczema, acne, sycosis, pityriasis versicolor, and scabies, as an excipient for the chosen medication, yielding more prompt results than when the same drugs were used with other bases. Where it is desirable to produce flexibility of the skin, it is best to mix it with twenty per cent of vaseline. In superficial inflammations, he uses lanolin alone. As a substitute for his well-known paste, he proposes the following:  $\mathcal{R}$  Ac. salicyl., 2.0; vaselin., lanolin., zinci oxid., amyli,  $\text{ââ}$  25. M. lenit. ter. f. pasta. He has found it extraordinarily useful in psoriasis, a twenty-five-cent chrysarobin-lanolin ointment causing all the efflorescences of an obstinate case of the disease to disappear in ten inunctions without the least irritation. It is very useful in seborrhœa capitis even without medicamentation, and makes an excellent pomade with carbolic acid or sulphur. For a rough skin, he recommends the following:  $\mathcal{R}$  Ac. carbol., 1.0; ungt. plumb. lanolin.,  $\text{ââ}$  20.0; ol. amygdal., 10.0; ol. lavend., gtt. xxx. M.—*Berl. Klin. Wochenschr.*, Feb. 1, 1886.

---

## Items.

---

**SYPHILITIC BUBO.**—Prof. Neumann, of Vienna, says that, as a rule, they need no treatment, as they disappear usually in the course of the disease without suppurating and without special treatment. Sometimes, if the initial lesion is irritated or the patient is subjected to severe bodily strain, as in long marches, the indolent bubo will become inflamed and may suppurate. He therefore advises rest as a prophylactic. If the inflammation is already active, the local application of cold will be useful. If the bubo is of considerable size, compression by means

of a sand bag, a truss, or an ice bag may be used. To reduce indolent bubos, he makes use of the local application of:

℞ Tinct. iodini.....30

If suppuration has begun, he opens the abscess early, and gives free exit to the pus. If the suppuration is slight, he punctures the abscess, and injects iodoform. In large abscesses, he advises free incision, scraping out all the *débris* of the broken-down gland, and cutting away all the very thin skin of the cover. The subsequent treatment consists in the use of iodoform. After the exit of the pus from a small abscess, he introduces a plug of iodoform gauze or of gelatin with one and one-half grains iodoform, each plug to be five centimetres long and five millimetres thick. He succeeds in healing the abscesses in eight days by this method. In large abscesses, he packs the whole cavity with iodoform gauze.—*Allgemeine Wien. Med. Zeitung*, December 1, 1885.

**SYPHILIS OF THE BRAIN.**—In this dangerous manifestation of syphilis, from whatever pathological condition arising, Dr. Gerhardt places his reliance upon mercurial ointment and iodide of potassium for treatment. If the treatment is begun early enough, many of the cases are curable; but if treatment is delayed, there is no hope. Treatment must then be begun early, and be energetic and long continued. He uses daily inunctions of ungt. hydrarg. in doses of three to seven grams, and administers at the same time from two to five grams of iodide of potassium. The more the patient moves about in the open air, the greater, proportionally, must be the amount of the ointment rubbed in.—*Berliner Klin. Wochenschrift.*, January 4.

**TREATMENT OF SYPHILIS BY SUBCUTANEOUS INJECTIONS OF OXIDE OF MERCURY.**—Dr. Watrazewski, of Warsaw, makes in this article another contribution to the literature of the hypodermic treatment of syphilis. He became dissatisfied with the hypodermic injection of calomel on account of the disagreeable general and local reaction to which it sometimes gave rise. After trying various other forms, he now uses exclusively either the black oxydulat (mercurous oxide), or the red oxide of mercury suspended in water and gum arabic, in the dose of 0.06 to 0.10 grams. This is repeated every six to eight days, and requires only three to five injections to cause a disappearance of the eruption. It causes little or no pain, and does not produce abscesses. The mercurous oxide seems milder than the red oxide.—*Centralblatt f. die Med. Wissenschaft.*, January 9, 1886.

**ACTION OF MERCURY ON THE BLOOD.**—According to the experience of Gaillard, the action of mercury on the blood of syphilitics consists primarily in a diminution of the number of globules and in the amount of hæmoglobin. Very rapidly, however, the normal standard for each is again reached, and even exceeded.

Mercury has surely, therefore, in syphilitics a hæmatopoetic and reconstructive action.—*L'Union Médicale*, September 29, 1885.

**SYPHILIS FROM TATTOOING.**—Dr. Trotter reports a case in the *Philadelphia Medical Times*, November 14, 1885, of a man who acquired the primary lesion of syphilis while being tattooed by a man who *wet the needle-holder in his mouth* to outline the design. Several weeks after the operation, an ulcer appeared on the figure last executed, and lasted for some time. Three months later a pustulo-squamous syphiloderm appeared on the back, and patches of the same broke out on other regions of the body.

# JOURNAL

OF

## CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

MAY, 1886.

No. 5.

---

### Original Communications.

#### A REMARKABLE NEOPLASM OF THE SKIN.

BY

JAMES H. DUNN, M.D.,

Professor of Genito-Urinary Surgery, Syphilography, and Dermatology in the Hospital College, Minneapolis, Minn.

**D**R. T., an American physician, aged 49, a small delicate man of nervous temperament, had for many years been ailing from obscure subjective symptoms, of which little definite is now known. For some two years past he had been supposed to suffer from pulmonary phthisis. He had moved out, and consulted many colleagues in different parts of the Union. He had suffered from extensive right pleurisy, and the right side sank in, and resulting lateral curvature of the spine occurred about one year ago. Father died of yellow fever; mother suffered from asthma, and said to have died of pulmonary apoplexy; sister died of phthisis. He was an excessive smoker. Had lived mostly in Florida and the South.

About three months ago he came to Minneapolis, under the care of Dr. F. A. Dunsmore, of this city, at whose request I was called to see him.

Dr. D. found the physical signs of absence of the right lung, increased resonance and bronchial breathing on the left; great exhaustion and nervousness; patient confined to bed; no notable elevation of temperature at this or any subsequent time.

*The Skin Lesion.*—The region of the right breast, extending from the second rib above to the border of the seventh rib below, from the posterior border of the axilla externally to past the mesial line, the skin and subcutaneous cellular tissue was occupied by a peculiar, irregular, nodular new growth, presenting a moderately firm hard feeling to the touch, the nodules varying in size from a small split pea to a hazelnut. No trace of ulceration at any point. The space included within a radius of about three inches about the nipple, corresponding to the older portion

of the growth, was composed of confluent nodules, so crowded and packed together as to increase the thickness of the skin at many points to nearly the extent of an inch, averaging, perhaps, some six or eight lines, forming a large irregular plaque, with uneven nodular surface. On the outskirts of this were larger or smaller nodular areas, of from four to six lines in thickness, and more or less completely confluent, having apparently appeared in patches from the size of a nickel to a quarter, and consisting of from three to eight nodules, which later, by the development of new nodules and the increasing growth of the primary ones, together with hyperplasia of the intervening skin, formed large irregular, intimately adherent tubercular masses, between which were disseminate nodules of the size of a split pea or larger. Beyond this territory were yet newer tubercles, all disseminate, but showing something of a tendency to a sort of circular grouping. The nodules, large and small, presented a firm,



doughy feel, and were of a color varying from purple to vermillion. The newer ones were covered with a nearly-normal cuticle, the older portions of the growth with a thickened verrucous epidermis, from which seemed to ooze very slowly a trace of serum, which dried down to a very thin buff-colored crust. The confluent masses below this crust presented a vermillion color from the increased vascularity of the cutis vera, while the spaces of intervening skin, especially at some points, were of a purplish hue, as if from passive congestion. To the eye, the whole territory appeared to be occupied with an irregular nodular mass, some distance above the nipple thicker and massed together, farther from it more scattered, but with some tendency to grouping and heaping up, yet everywhere infiltrated and occupied by disseminate tubercles. It was nowhere adherent to the deep fascia. There was very slight enlargement of the right axillary glands, one being nearly the size of a filbert, but no other glandular enlargements. None of the nodules were movable beneath the skin, but



all implicating and chiefly located in the derma. No melanotic pigmentation. It had spread from the vicinity of the nipple irregularly in all directions. Patient had complained of slight, uneasy, burning sensations in the involved skin at times, though it was not painful to the touch, and there were some pains of a neuralgic nature in the course of the intercostal nerves of that side, due, perhaps, to the lateral curvature and contraction above referred to, in an exhausted and neurotic subject. The duration of the growth, from the first appearance of a group of nodules in the region of the nipple till death, was seven months, during which time it had steadily grown to the above dimensions, by the appearance of of new nodules in the outlying healthy skin, as well as among the primary ones in the areas already involved.

Death from exhaustion, after four months' constant confinement to the bed, with great restlessness and defective assimilation. Toward the end there was mild delirium and occasional hallucinations, very likely from cerebral anemiæ. On waking, he often referred to two negroes perched upon the curtain pole of his window.

The autopsy, made by Dr. C. H. Hunter, pathologist to the Minneapolis Hospital College, gave evidence of an old right pleurisy, evidently a so-called quiet pleurisy with effusion, which had seemingly been overlooked before his arrival here, as patient did not seem to be aware of any such diagnosis. Almost complete obliteration of right lung, traces of pulmonary tissue forming a small stump at what had been its root, and the changes secondary to obstructed pulmonary circulation; viz., hypertrophy of the right heart, dilated aorta, old endocarditis with thickened valves, but not permitting regurgitation; nutmeg liver. Kidneys small but normal, except a slight hydro-nephritis. The left lung was studded with many small solid nodules, of the size of a wheat corn, scattered beneath the pleura, and to a less extent throughout its stroma, and presenting a few pleuritic adhesions, otherwise apparently healthy. The mesentery was shortened and drawn up, and attached by its free border to the left inguinal region. At about its centre was a nodule one and one-fourth inches long by one-half inch in thickness, surrounded by numerous smaller nodules, the evident cause of the shortening. The cut surface of these nodules presented a homogeneous white surface streaked by yellow lines, particularly marked at the centre, indicative of fatty degeneration. The stump of the right lung, of the size of a turkey's egg, when cut through, presented a collection of larger or smaller bronchial tubes and vessels with hyperplasiæd connective tissue, from which a foul pus exuded, the evident source of the more or less scanty purulent expectoration of the patient. The parietal pleura was immensely thickened, and the much contracted cavity nearly filled with bloody serum. No nodules discoverable in the remains of the right lung. Microscopical

examination of the nodules of the left lung and mesentery by Dr. Hunter showed them to be richly cellular structures, cells of various shapes, but of connective-tissue origin, with scanty stroma. Microscopical examination of the skin, by Dr. Hunter and by the writer, showed the seat of the new growth to be the papillary and deeper layers of the corium. The papillæ were everywhere greatly elongated, running up through the rete mucosum by pointed tongue-like prolongations, often branching into two or several slender filaments. Scattered through the fibrous reticulum of the papillæ, and more especially at their base and the upper layers of the pars reticularis, were numerous nucleated cells distinctly of the epithelial type, showing a marked tendency to arrangement into nests separated by bands of connective-tissue. Towards the lower strata of the reticularis there appeared to be a marked increase of fibrous and elastic elements; at points, indeed, this was so far the case that the nodules appeared to be poor in cellular elements. The seat of the cellular growth was chiefly in the papillæ and the layers of the corium immediately beneath. At no point could the proliferation of epithelioid cells be traced down from the epidermis, nor were any of the so-called "pearls" so common in epithelioma discoverable. Though not presenting a typical picture of epithelioma, repeated examinations left no doubt in the minds of Dr. H. and the writer that the growth was carcinomatous.

Diagnosis.—Carcinoma cutis.

Remarks.—So far as my observation and reading goes, the case is most interesting, if not unique.

The location, small size of the nodules, method of eruption, tendency to grouping, slight implication of glands, strict limitation to the derma, small extent of internal deposits, and these, *if malignant* (this not demonstrated), in organs only connected through the circulation of the blood, together with the location over a lung cavity, long the seat of irritation and continued pathological processes, render the neoplasm not only extraordinarily interesting, but raises many queries and speculations which, since they are probably unanswerable in the present state of our knowledge, it were folly to record.

It seems hardly probable that the skin lesion was secondary to the visceral nodules, though those in the mesentery may have been, and probably were older than the cutaneous growth. Before repeated microscopical examinations were made, and rendered the diagnosis untenable, the growth was thought to be sarcomatous, though its course, history, and appearance would, farther than the lack of ulceration, lend but slight encouragement to the opinion. By exclusion, epithelioma was rejected, largely on account of the long duration and great extent of growth without ulceration, as well as the very multiple method of appearance.

## NOTES ON A CASE OF LICHEN SCROFULOSUS.

BY

WM. S. GOTTHEIL, M.D.

**L**ICHEN scrofulosus s. L. scrofulosorum is an affection of fairly rare occurrence. Neumann<sup>1</sup> rates its frequency at 0.3 per 100 cases of skin disease in adults, and at 0.5 per 100 cases in children. L. D. Bulkley,<sup>2</sup> in an analysis of 8,000 cases occurring in a public and private dermatological practice, records but a single case. Probably its frequency in this country is not greater than 1 in 5,000 cases of skin disease.

The literature of the disease in English is quite scanty. Two cases have been reported here, one by E. B. Bronson,<sup>3</sup> and one by F. S. Shepherd.<sup>4</sup> In England, Tilbury Fox<sup>5</sup> has described a series of six cases, and H. Radcliffe Crocker<sup>6</sup> has reported one. On the continent, the affection seems to be of somewhat commoner occurrence, especially in Vienna, where the elder Hebra first differentiated and described it. Lailler<sup>7</sup> and Hardy<sup>8</sup> describe cases of the malady, but do not mention its frequency.

All the recorded cases show a very marked agreement in their clinical features. All occurred in young persons, and most of them in children; the youngest case being seven years old, and the oldest twenty-two. In spite of Kaposi's<sup>9</sup> dictum that the disease is confined almost entirely to men, six out of the nine recorded cases occurred in females. In all instances save one, the eruption presented the characteristic appearance of larger or smaller, sharply-defined groups of isolated, brownish-red and slightly scaly, pin-head sized papules, scattered in greater or less abundance over the body. In the one exceptional case of Tilbury Fox, the lesions were not grouped, but were disseminated irregularly over the entire surface. Subjective manifestations were practically absent. Finally, in every case there was present more or less markedly some

<sup>1</sup> Neumann, "Hautkrankheiten," Art. L. Scrofulosorum.

<sup>2</sup> L. D. Bulkley, "Analysis of 8,000 cases of skin disease," Archiv of Dermat., Oct., 1882.

<sup>3</sup> Bronson, "Case of Lichen Scrofulosus," Arch. of Dermat., i., p. 138.

<sup>4</sup> F. S. Shepherd, Canada Med. and Surg. Journal, 1880-1, v. ix., p. 280.

<sup>5</sup> Tilbury Fox, "Trans. Lond. Clin. Soc.," v. xii., p. 190, 1879.

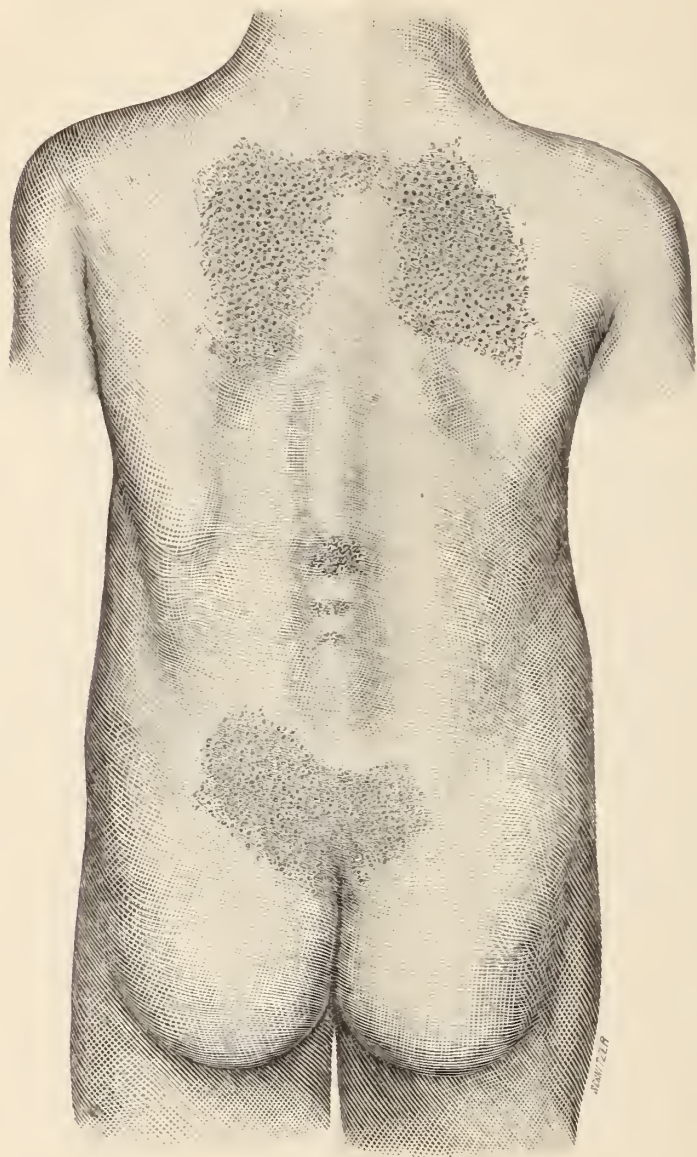
<sup>6</sup> H. Radcliffe Crocker, "Trans. Lond. Clin. Soc.," v. xii., p. 195, 1879.

<sup>7</sup> Lailler, La France Méd., 1877, pp. 513, 530.

<sup>8</sup> Hardy, Gaz. des Hôp., 1877, pp. 1161 and seq.

<sup>9</sup> Hebra u. Kaposi, "Lehrbuch der Hautkrankheiten," Art. L. Scrofulosorum.

manifestation of those chronic inflammations with a tendency to early caseation which we call "scrofula," or there was true tubercular disease.

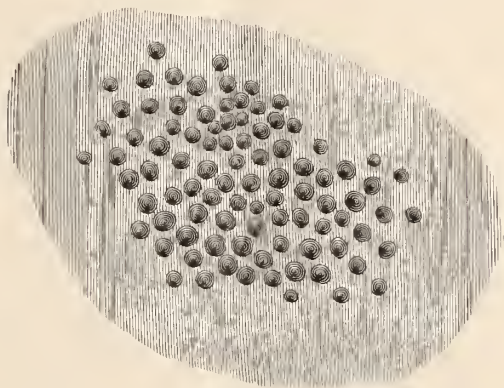


Three cases suffered from chronic bone disease; three had had hæmoptysis and other lung symptoms; two had chronically inflamed sub-



maxillary glands; one had lupus erythematosus of the face; and in four cases, there was a well-marked phthisical family history.

The patient, Eddie Bradley, of whose case the accompanying drawing is a fairly accurate representation, was first seen on July 22, 1885. There were then upon his body ten groups of the eruption, exactly similar to one another, and uniformly composed of aggregations of round, pin-head sized, brownish-red, flattened, slightly scaling papules, the skin between the elevations being perfectly normal, and the individual lesions showing no tendency to coalesce. No acne papules or scratch-marks were present. On the abdomen, midway between the umbilicus and the pubes was a narrow semicircular patch some seven inches long, with its concavity turned upwards, and above this on either side, in the mammary line, another smaller one. Posteriorly, two large patches, some six inches in diameter, occupied each the region of one shoulder-blade, being joined by



a connecting band of eruption at their upper border; whilst just above the beginning of the natal fold was another and more irregular group. Four smaller patches occupied the hollow of the back. The extremities were free, as they almost invariably are, with the exception of two well-marked quarter-dollar-sized patches situated in the skin one at either side of the right ligamentum patellæ.

The patient is a boy nine years of age, and is in perfect health. It is worth noticing that no trace of strumous or scrofulous taint is to be found about him, and that the family history is exceptionally free from phthisis. The patches had certainly existed for two years, if not for a longer time, and had caused no further annoyance than a slight occasional itchiness. They were noticed first upon the abdomen, and had slowly grown to their present extent. According to the mother's statement, the area of affected skin was increasing in size at the present time; but no disappearance of any patch once formed had been noticed. The boy was kept under ob-

servation for some months without treatment; but not the slightest change was noticed in any of the old papules, nor did any new ones appear. Under the free use of cod-liver oil internally and externally, the papules are gradually flattening out and the patches are fading away.

7 W. 50TH STREET.

## THE BULLOUS FORM OF IODIC ERUPTION.

BY

PRINCE A. MORROW, A.M., M.D.,

Clinical Professor of Venereal Diseases, University of the City of New York, Surgeon to Charity Hospital.

(Concluded from page 100.)

AS before intimated, the literature of this eruptive form is comparatively limited. As early as 1842, Ricord<sup>1</sup> refers to a rupia-like eruption, presenting the characters of a cachectic rupia, which he had observed upon the forearms and legs of a patient who was taking iodide of potassium. The eruption disappeared upon discontinuing the drug, and reappeared when its use was resumed. While this eruption was probably closely allied, if not identical, with that under consideration, its clinical characters were not traced with sufficient precision to justify its inclusion under this category. The first authentic case of bullous eruption caused by iodide of potassium was reported by Dr. John O'Reilly in the *New York Medical Gazette*, January, 1854. In a paper read before the American Dermatological Association, in 1879, Dr. J. Nevins Hyde<sup>2</sup> gives a very interesting resumé of our knowledge of the bullous eruption induced by the ingestion of iodide of potassium. In connection with a case which came under his observation, he gives a tabulated statement of the clinical features and other points of interest in fifteen cases which he had found recorded up to that time.

He includes in his statistics five cases of Hutchinson, three of which, it must be remarked, are of somewhat doubtful authenticity, as the pathogenetic action of the iodide was not suspected when the cases were under observation, and in one case it was not definitely known that the patient had taken the drug. But as the nature and origin of the eruptions were at the time obscure, and, moreover, they bore such a striking resemblance to a bullous eruption caused by iodide of potassium in two patients subsequently observed by Hutchinson, he classed them all as "hydroa from iodide of potassium."

<sup>1</sup> Ricord, *Bulletin Gén. de Thérapeutique*, t. xxiii., 1842, p. 162.

<sup>2</sup> Hyde, *Archives of Dermatology*, October, 1879, p. 333.

Since the appearance of Dr. Hyde's paper, I have found reports of a number of other cases: O'Reilly's case, which had been overlooked by Dr. Hyde; one case reported by Thin;<sup>1</sup> two cases reported by Hallopeau;<sup>2</sup> one case by Besnier;<sup>3</sup> one case by Pellizzari;<sup>4</sup> one case by Lindsay;<sup>5</sup> one case presented by myself<sup>6</sup> before the New York Dermatological Society, and a second case, which forms the subject of this paper.

From a careful study of these cases, the general characteristics of the bullous form of iodic eruption may be thus described:

*The Quantity of the Drug Required to Develop the Eruption.*—In a majority of cases, the quantity of the drug ingested seems to have been immaterial, its irritative effect upon the skin being determined rather by the idiosyncrasy or susceptibility of the individual. In some cases, small doses—smaller indeed than are required to produce the ordinary physiological effects of the drug—sufficed to bring out the eruption. In one case, a single dose of 5 grains; in another, two doses of  $7\frac{1}{2}$  grains; in another, three doses of 15 grains; in three cases, 1 drachm; in one case, 4 drachms; and in one of my cases, 900 grains. It will be remembered that in this case the cutaneous phenomena began to appear after 300 grains were taken, and were intensified in severity and extent by the continued use of the drug after symptoms of intolerance had declared themselves. In some of the cases, the eruption was developed a number of times, either because the toxic action of the drug was not recognized, or because the observer wished to test the susceptibility of the patient, and it is worthy of note that, while it may have required large and continued doses to produce the eruption in the first place, much smaller doses sufficed to promptly redevelop a succeeding outbreak. In Besnier's case, the eruption was first developed by 2 grams, the second time by 1 gram, and the third time by 10 centigrams.

*The rapidity with which the eruption develops.*—The length of time which intervenes between the administration of the drug and the first appearance of the eruption varies according to the predisposition of the individual and the size of the dose; usually it is from the third to the sixth day. Exceptionally, this period may be reduced to a few hours or lengthened to several weeks. In one case (Dulring's, referred to by Hyde) it was only four hours; in two cases, twelve and twenty-four hours; in one case, three weeks; in another, two months; in the greater number, from three to six days. In Besnier's case, a single dose of the iodide

<sup>1</sup> Thin, "Medico-Chirurgical Transactions," 1879, p. 189.

<sup>2</sup> Hallopeau, L'Union médicale, No. 41, 1882, p. 481.

<sup>3</sup> Besnier, Annales de Dermatol. et Syphilig., March, 1882, p. 168.

<sup>4</sup> Pellizzari, Archives of Dermatology, July, 1881, p. 267.

<sup>5</sup> Lindsay, British Medical Journal, March 19th, 1884, p. 602.

<sup>6</sup> Morrow, JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, Dec., 1884.

taken at night was followed the next morning by itching and the development of bullæ and pemphigoid phlyctenulæ. This experience was repeated three times in succession.

*The locality of the eruption.*—The bullous eruption has for its seat of predilection the face, neck, and dorsal surface of hands and wrist; sometimes it is seen upon the lower extremities, more rarely upon the trunk. In two instances it occurred upon the palms, and twice on the mucous membrane of the mouth. It has been observed but once upon the hairy scalp. In the case reported by O'Reilly, the bullæ were situated upon the forehead, lips, under left clavicle, inner side of right thigh and side of prepuce. In one of Hallopeau's cases, the face and hairy scalp were the seat of the eruption; in the other, the parts of the cranium devoid of hair, the forehead, eyelids, and backs of hands. In Thin's case, the face and dorsum of the hands; in Besnier's case, the head, neck, chest, and arms; in Pellizzari's case, the arms and legs; in Lindsay's case, the face, trunk, and upper extremities; in both of my cases, the face, neck, and dorsal surfaces of forearms, wrists, and hands were the localities affected.

*Clinical features.*—The special features which characterize this eruption are the development of bullæ of varying size, often commingled with vesicles and small pustules. The lesions usually make their appearance as vesicles or vesico-pustules which rapidly increase in size; they may remain discrete, or coalesce with neighboring bullæ. In other cases they begin as hard papules, the shot-like character of the papules suggesting the commencing stage of variola. This resemblance is heightened by the rapid transformation of the papules into vesicles, and their tendency to umbilication, which is quite manifest in some cases. There is generally more or less thickening or infiltration of the skin, and the lesions may be surrounded by an inflammatory areola, variously described as "erythematous," "bright red," or "a dark wine color." In some cases the epidermis is uplifted without inflammatory swelling of the skin, presenting the appearance of a blister produced by a burn. In Hallopeau's cases the bulla was the initial lesion, the erythema developed secondarily. In Lindsay's case the eruption was described as "an eruption of blisters, compared to 'potato apples,' each blister surrounded by a series of bright-red concentric rings."

*The size of the bullæ.*—The lesions are variously described as the size of a "pea," a "lentil," a "cherry," "pigeon's egg," "one and a half inches in diameter," "very large," etc. It is obvious that their volume will depend somewhat upon whether they remain discrete or become confluent, in which case they may attain enormous dimensions. The exaggerated development of all the eruptive features in my second case was doubtless due to the continued use of the drug after its toxic action had begun to be manifest.



*Contour.*—The lesions are regularly-rounded or semi-globular when discrete; irregular or sinuous when formed by the fusion of neighboring bullæ. Exceptionally the lesions may present a distinctly umbilicated appearance.

*Color.*—At first “pale,” “yellowish-white,” “waxy yellow;” later, “reddish,” “purplish,” “dark purple,” “color of intestine,” “dirty-blue,” etc.

*Consistence.*—The lesions are tensely distended, and more or less firm, in two cases suggestive of tumors filled with solid contents.

*Contents of lesions.*—At first clear serum, which later becomes turbid, assuming a latescent or grayish-opaque color, sero-purulent or sanguinolent. If the bullæ do not rupture readily, the contained fluid may degenerate into a thin, bloody pus, extremely offensive. In one case microscopical examination of liquid showed presence of red globules and large number of white globules, certain of these elements in process of degeneration, also considerable number of vibriones. The exudation of red blood-corpuscles sometimes, though rarely, occurs in the initial stage of the bulla. Contents of bulla have been repeatedly examined for traces of iodine, but always with negative results.

*Duration of eruption.*—The bullous form is no exception to the general law of drug eruptions, “*sublata causa, tollitur effectus.*” In any case, no matter how marked the cachexia, or how grave the organic complications, the eruption begins to improve soon after the withdrawal of the offending cause. Its more or less rapid involution depends, of course, upon the severity and extent of the lesions and the recuperative powers of the individual. The walls of the bullæ rupture and discharge their contents, which dry up, forming thin crusts; upon falling they leave pigmented spots. In some cases there is a slight ulceration of the floor of the bullæ, involving the upper layer of the corium, which leaves superficial scars. Some authors speak of successive ulcers following the bullæ. In O'Reilly's case there was sloughing of the parts upon which the bullæ were situated; the penis was sphacelated, and entirely thrown off up to the pubes.

*Co-existence of renal and cardiac complications.*—In five of the nine cases which I have collated, cardiac complications were noted as being present, in three of the cases associated with albuminuria. They may have existed in other cases without having been detected. As previously pointed out, we can readily understand why defective elimination of the drug should act as a co-factor in the causation of cutaneous irritation. The greater part of the iodine is normally eliminated by the kidneys within twenty-four hours after its ingestion; when this channel of egress is blocked up, the drug is longer retained in the vascular channels, and exerts its irritant action upon the tissues. But why cardiac

disorders should produce a morbid determination of the drug's action towards the cutaneous system is not so evident. Thin has suggested that this may be due to the feeble heart impulse and consequent sluggish circulation in the cutaneous capillaries, allowing the iodine or its compounds present in the blood time to attack and injure parts of the vascular wall. It is needless to say that the retarded elimination of the drug does not explain the occasional occurrence of the eruption within a few hours after the ingestion of a single insignificant dose.

*Fatality.*—Death occurred in four of the nine cases. As is well known, the disturbance of the general health from a drug eruption is, in the great majority of cases, slight and of transient duration, and its influence upon mortality practically *nil*. The fatal termination in these cases was doubtless due to the existence of grave organic lesions, although in all of them a considerable quantity of the drug had been administered. Thin's patient, who had "renal and mitral regurgitant disease," died nine days after the appearance of the eruption. In Hallopeau's patient, who had "aortic contraction with valvular insufficiency and slight albuminuria," death occurred on the twentieth day after the eruption began to appear. Pellizzari's patient, in whom the eruption was repeatedly developed, died several months later from "heart disease," and my own patient, who had "mitral insufficiency and atheromatous deposits, with albuminuria," died six weeks after the eruption first appeared.

*Histological appearances.*—In two of the cases a microscopical examination of the lesions was made. Hallopeau found that the bulla was situated in the median part of the mucous body, which was in part destroyed, papillæ of the derma not involved. The walls of the bulla were composed of the horny layer considerably hypertrophied, the stratum granulosum, and a part more or less considerable of the rete mucosum, which remains adherent to the stratum. Thin found the roof-wall to be composed of a ragged, and partly disintegrated epidermis. The appearances indicated that the formation of the bulla was the result of an injury to the walls of the blood-vessels of a limited area, attended with effusion of the constituent parts of the blood, the pressure of which displaced the bundles of connective tissue, ruptured the mucous layer of the epidermis, and accumulated under the horny layer of the epidermis, as is the case with all similar effusions. The size of the bulla and the nature of its contents depend in such cases upon the degree and extent to which the vascular wall is damaged, and on the size of the affected vessels.

Certain additional points of interest in connection with the bullous form of iodic eruption may be alluded to. As a rule, the vesicular element is alone present; exceptionally it may be accompanied with other eruptive elements, constituting a polymorphous eruption. In Pellizzari's case, three eruptive forms of an entirely different character were

present at the same time. On the left forearm near the wrist there were three slightly elevated papules the size of a cent, with a rough surface and of a dark strawberry color. Upon the arms and legs were eight or ten lesions about one-half inch in diameter, similar to the bullæ of rupia, with a rather deep base, surrounded by a circumscribed dark-red areola; on the top, a bulla like that produced by a burn. The third form was represented by three tumors, from the size of a nut to that of an apple, deeply seated in the subcutaneous tissues. In the case presented by me before the New York Dermatological Society, there was present a variety of eruptive elements, papules, tubercles, furuncles, vesicles, pustules, and bullæ.

In a majority of cases, the eruption is preceded by subjective sensations of burning and itching; it may or may not be accompanied by the ordinary physiological effects of the drug. In aggravated cases, there may be cephalalgia, iodic fever, with considerable elevation of temperature, and the group of symptoms peculiar to constitutional iodism, such as profound depression, insomnia, tremors, etc.—the result of the toxic action of the drug upon the nervous system.

One or two conclusions of practical interest may be drawn from this clinical study. 1st. This form of iodic eruption may be confounded with variola and syphilis. As Hutchinson has pointed out, the shot-like character of the papules which precede the development of the bullæ resemble those of the early stage of variola. The localization of the eruption and the tendency to umbilication are additional elements of confusion. The free exudation from the broken bulla, with the admixture of blood, may form crusts not unlike those of syphilitic rupia. Hyde has suggested that the “rare vesicular and bullous lesions, recorded as occurring in acquired syphilis, may have been induced by the administration of iodide of potassium for the relief of the disease.” 2d. The proneness of this eruptive form to develop in connection with cardiac and renal disorders, suggests the necessity of observing a certain amount of caution in administering iodide of potassium to patients in whom these complications are known to exist.

The following conclusions in regard to this eruption may be formulated:

1. The bullous form of iodic eruption is comparatively infrequent.
2. It has for its seat of predilection the face, neck, forearms and hands, exceptionally it may occur upon trunk and lower extremities.
3. There seems to be no definite relation between the amount of the drug ingested and the production of the eruptive accidents; they may follow, indifferently, a single insignificant dose, or may appear only after the long-continued use of large doses.
4. In the former case, the incidental effects of the drug upon the skin

depend upon idiosyncrasy, in the latter class of cases the pathogenesis is more obscure.

5. The proneness of this eruption to develop in connection with cardiac and renal disorders would seem to indicate that these conditions stand in the relation of a determining cause, rather than a mere coincidence.

6. The practical inference may be drawn that caution should be observed in the administration of iodide of potassium when these complications are found to exist.

---

### CASE OF ERYTHEMA VENENATUM.

BY

FREDERICK W. PUTNAM, M.D.,

Binghamton, N. Y.

MY reasons for presenting a report of this case are the peculiar clinical history attending it, and the possibility of error in diagnosis.

Dec. 7, 1885, Mrs. F., Irish, of this city, called at my office and said her five-year-old boy had a sore throat, but that he was not very sick, and she wished me to give her something for the throat trouble. I gave her powdered muriate of ammonia, a favorite remedy of mine in such conditions.

The next day I was sent for in great haste. Upon reaching the house, she said that the patient had been vomiting all day, and that he had a red eruption upon his body. He had had only a slight evacuation from his bowels in the past forty-eight hours. He complained of his throat, and had some fever, with a pulse of 120. The tonsils and surrounding structures were simply hyperæmic. I did not note the temperature. His cheeks were not flushed and his skin was not unusually hot. His tongue was covered with a whitish fur, except at the extreme tip, which looked a good deal like the beginning of the "strawberry tongue." Still the papillæ were not unduly raised. Upon his body was a fine, punctate, but pretty generally diffused scarlet eruption.

The boy had never had scarlet fever, and cases of it were occurring here and there about the city. Here was a case of a boy, five years of age, who never had had scarlet fever, who had some sore throat, who had been vomiting more or less for twenty-four hours, whose tongue was covered with a whitish fur, who had some fever, and who had a punctate



and more or less diffused scarlet eruption appearing on the second day of illness. Certainly a very fair clinical history of scarlet fever.

This boy was evidently a comparative stranger to the cleansing influences of soap and warm water, and a fair supply of "mother earth" was adhering to his integument. In arriving at a diagnosis, this admixture of dirt with the eruption had to be eliminated. By selecting a portion of the chest least covered by extraneous matter, I discovered that no line remained after drawing the finger over the surface, even for an instant. I also noticed that the eruption extended only midway up the neck, and did not extend down on the thighs. About the middle of the neck there was a distinct line extending completely around the neck, between the eruption and the healthy skin. Up to this line, the eruption was very prominent; above it, there was no eruption.

The boy had been wearing a new cheap red-flannel undershirt for four days, and I discovered that the top of the shirt and the upper border of the eruption were in the same plane.

I directed the mother to remove the shirt, and the boy made a rapid recovery. I gave him one cathartic dose of hydrarg. submuriate, and small doses of tr. of aconite root every half-hour for the remainder of the day, and directed him to continue the ammonia.

I believe that the throat trouble was simply a coincidence, and that the systemic disturbance was due to the poison contained in the coloring matter of the shirt.

---

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

162D REGULAR MEETING, MARCH 23, 1886.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. JACKSON presented a case of

#### GENERAL CHROMOPHYTOSIS.

A German, about 35 years old, who, for the past five years, has had a pretty general eruption of chromophytosis scattered over the trunk and upper extremities. The patient enjoys good health, with the exception of excessive perspiration.

DR. CAMPBELL showed three cases of

#### MERCURIAL STOMATITIS.

A woman and her two children, who have been salivated for the past five or six weeks. The woman says that she purchased some canton flannel that had been

used to wrap around mirrors, and thus became impregnated with the quicksilver. She states that two or three days after washing the flannel, her mouth became sore and her teeth loosened; her children were similarly affected. When first seen, the patients presented all the appearances of mercurial stomatitis, with the mercurial odor quite prominent. The woman denies having taken any kind of medicine, or having used any local remedies previous to the occurrence of the symptoms of salivation.

DR. TAYLOR exhibited a

PECULIAR CASE OF DISCOLORATION OF THE SKIN IN A PATIENT SUFFERING FROM  
CIRRHOSIS OF THE LIVER.

M. T., Irish, laborer, 57 years of age, was, according to his statement, well until eight months ago. He has always worked hard, has been much exposed to severe weather, and during the past twenty years has been addicted to alcoholics. Within the past year, the patient's appetite has been poor; he has lost in weight from fifteen to twenty pounds, and is much reduced in strength. His complexion is of a dark, muddy color. On physical examination, the liver was found much contracted, and the spleen enlarged to twice its normal size. The urine was frequently examined and found to be of high specific gravity, small in quantity, and contained large quantities of urates and blood pigment. About a year ago, his feet began to swell, and he walked with less ease than formerly. Coincidentally with the swelling of the feet and legs, the latter became the seat of pigmentation, which is well shown in the drawing to involve chiefly the middle portion of the legs in an irregular, but generally continuous patch. The remaining portion of the integument of the legs and feet was somewhat darker in color than normal. There was, however, nothing unusual in the pigmentation of the leg more than is often seen in cases of chronic oedema of these parts, and following eczema and varicose veins. The peculiar and unusual discoloration begins over each patella and, running up in a patch on the inside of the thigh, ends just below the lower border of the scrotum. It may be well to state here that, although there is not strictly a varicose condition of the veins, the walls of these vessels can be distinctly felt to be thickened.

Over the patellæ there is a patch of very dark brown discoloration, which is continuous with the patch on the inside of the thigh which there becomes studded with irregular-shaped spots of normal skin, the whole presenting a clearly defined mesh or network, the brown portion of which is rather more extensive than the white. As the patch is followed up the thigh, it becomes narrower until it ends at about the opening in the fascia for the femoral vessels. The appearance of the pigmentation is peculiar and interesting. Beginning at the knee as a deep brownish-black patch, it gradually diminishes in intensity until at the periphery of the patches it is lost. Above this, under the skin, can be seen a faint but perceptible coloration, in a mesh form, which seems to be due to the appearance of the venous radicles through the skin, which is here thin and delicate. The latter condition of the veins can sometimes be seen in persons having a delicate skin after a cold bath or exposure to cold. My explanation of this abnormal chromatogenous development is that it is due to stasis, caused by impediment to the circulation from visceral disease, and that the affected cutis is permeated with pigment of the blood which has escaped from the vessels, and that the mesh-like appearance of the patches is due to the changes which have taken

place in the integument immediately over the large veins of the thighs. In this case, there was no prominence of the veins over the abdomen.



DR. SHERWELL believed it to be a venous stasis, and that the ecchymosed condition showed a low state of health due to excessive indulgence in stimulants.

DR. BRONSON said that he was under the impression that he had observed a similar condition in the region of the knee. An interesting point arises whether the discoloration of the skin is due to a deposit in the corium or not.

DR. ROBINSON had never seen pigmentation above the knee, with so little varicosity. The pigmentation was in his opinion due to an enlargement of the capillaries.

DR. ALLEN had seen pigmentation about the thighs in persons affected with syphilis.

DR. MORROW thought that hæmorrhagic points in this situation, resembling a

purpura, was an interesting feature. A point worth determining was, whether these spots were due to the bandaging or the administration of the digitalis.

DR. TAYLOR considered the case an interesting one also from a medical point of view. In persons with cirrhosis of the liver there is often a large abdomen, with varicose veins; the legs are also attenuated like pipe stems. This man's abdomen is not enlarged and the legs are about normal in size. The ecchymoses on the legs spoken of by Dr. Morrow are due to the pressure of the bandage.

DR. ROBINSON presented a case of

#### KERATOSIS OF THE NAILS.

The patient, a man, 26 years old, has had thickening of the nails ever since he was eighteen months old. All the nails of the hands are thickened to a greater or lesser extent; some as much as three quarters of an inch. There are also on the sides and the fore edges of the nails papillomatous-like growths. Both heels are thickened and macerated, presenting very deep fissures which cause great pain in walking. There is also considerable hyperidrosis.

DR. BRONSON thought that the case resembled a class of cases described by Unna in which there was a marked hereditary tendency. He had seen many cases resembling this one, but they occurred on the feet of elderly people. He had never seen a case occurring so early in life.

DR. LUTZ, of Germany (by invitation), said that he had seen the cases described by Unna, and in them there was marked thickening of the palms as well. There was marked pigmentation in patches, such as is often seen in cattle. In this case the malformation of the nails is peculiar, in being so regular, in contradistinction to onychogryphosis where the thickening is irregular.

DR. ROBINSON said that he showed the case because of the peculiar regularity in the thickening of the nails, which had already been referred to, and the smoothness of their upper surface. Where there is no friction it appears to be a papillomatous growth, occasioned by hypertrophy of the papillæ. He had never seen a case like it occurring in early life. He proposed applying nitric acid to the growths.

DR. MORROW suggested the use of salicylic acid locally.

DR. SHERWELL presented a case of supposed

#### LUPUS OF THE LARYNX.

Mabel P., 16 years old. No history of any disease in her immediate family. Four near relatives of her mother have died of what was diagnosed as carcinoma.

About four years since, without any marked antecedent symptoms, a succession of profuse hemorrhages came on, unattended with pain, and apparently from the larynx. About four days after, an eruption appeared, fugitive in character, appearing and disappearing rapidly and confined to lower limbs, which seems from description to have been erythema multiforme; certainly did not resemble a specific eruption. From this time forth she commenced to grow aphonic, and this has persisted up to present time.

In September, 1885, complete aphonia existed. On examination with the laryngoscopic mirror, I found tubercular excrescences or nodular infiltrations on and below vocal cords, notably about both commissures; the same irregular nodes over the site of arytenoid cartilages, and the epiglottis had lost about one-quarter of its size from the free edge backward, from an ulcerative process then present and active, of a slow, erosive, worm-eating kind. Also on the palate just above uvula there was present the same infiltrated and worm-eaten ulcer that is now present, but of greater extent and the borders more pronouncedly thickened than at present.

She was given various remedies, both local and general; among others, anti-syphilitics, but without much effect. Afterwards tonics and hæmatics were given, under which her general health was improved.



Lately I have been using the faradic current externally over crico-thyroid; there seems to be gradually more evidence of movement and an approach to approximation of the thickened cords, or what is left of them.

I have not, however, gotten much benefit from applications to the ulcer on palatal arch; and the ragged left tonsil, from which I at one time ablated a piece about the size of the last phalanx of her little finger, seems to be growing large again from proliferation of tissue of some kind. The conviction has been gradually growing upon me that we have here a lupus of the tissues, a disease we know to be quite rare in this locality.

DR. BRONSON thought that it would be necessary to have more data before making a diagnosis, but his impression was that the lesion progressed more rapidly than a lupus ordinarily did.

DR. LUTZ said that the clinical appearances were those of a lupus or a tuberculosis.

DR. ROBINSON would call it a local tuberculosis.

DR. SHERWELL thought that lupus was the best name to give the lesion, although he still held the diagnosis *sub judice*. The patient at no time has shown any evidences of phthisis pulmonalis. He does not believe it to be a carcinoma because there has been no pain worth mentioning.

DR. ROBINSON then showed a case of

#### NERVE NÆVUS.

The patient, a child five months' old, has a sharply defined, slightly elevated eruption existing on the shoulder, and extending down on the flexor surface of the arm of the left side. It made its appearance soon after birth, and is of a dark brown color.

DR. LUTZ said that in Germany a lesion would not be called a nævus, unless there was a certain amount of vascularity. This presented features both of keloid and papilloma.

DR. ALLEN afterward presented a case of

#### VEGETATING SYPHILODERM OF THE FACE.

The patient, Mrs. E. W., colored, about 40 years old, presented herself June 24, 1885, for treatment, having an enormous cauliflower-like appearance of the nose, fissured, ulcerated, covered with *dirty crusts, and foul-smelling*. She stated that it had begun two years before, as a pimple in the nostril. Her husband had been healthy, and she had never been sick before; nor did she give any history pointing to syphilis, except that nineteen years ago she had an eruption on her shoulders (probably acne), and had lost two children, one "with lumps in its neck." She has four healthy children living. For a month, she was given the mixed treatment, and locally mercurial plaster was used with some benefit. From July until the middle of August, the affected parts were painted with pyrogallol, forty grains to one ounce of collodion, the mixed treatment being continued, and the improvement was very marked. From the middle of August to the first of October, she was without any treatment, and the disease grew worse, but improved again under the internal treatment and pyrogallol until October 26, when the mixed treatment disagreed with the stomach, and it was discontinued. From now on to December 15, when she was last seen, pyrogallol alone was used, and the improvement was more marked than under the internal treatment.

The points of interest in the case are: 1st, that two months previously to December 15, when he had showed the case to the Society as a possible lupus, only local treatment with pyrogallol had been used, and the disease was almost cured

under it alone. The question arose whether a syphilis would have been so benefited by local treatment, or whether the good results were due to the mixed treatment which the patient took from June to October without much benefit to the nose during the time.

2d, That when patient was last seen, in December, the appearances were very much those of a lupus. There were some reddish-brown papules, somewhat pulpy, and some yellow points in the infiltrated tissue, which broke down easily upon being bored into. The surface of the patch was covered with fine epidermic scales.

3d, That the absence of a specific history and of other lesions and symptoms made it appear like a lupus hypertrophicus.

4th, That now, after an absence of over three months, the patient returns with the warty, exuberant growth again developed upon the sides of the nose, and ulceration extending into the nostrils. She now complains of osteocopic pains in the head, chest, and legs, worse at night, and under pressure and concussion, soreness of throat, and roof of mouth. Examination shows a deposit in the soft palate, which is probably gummy, and in which ulceration has begun. These signs, which were before absent, now do away with any doubt that may have existed as to the diagnosis.

Dr. TAYLOR questioned very much whether the lesion was a syphilide, because it had lasted so long and with so little destruction of tissue; still that, of itself, would not invalidate the diagnosis of syphilis.

Dr. JACKSON said that it reminded him of the case of rosacea hypertrophica that he had presented to the Society a short time ago. In that case, the lesion improved at first under local treatment, but afterward broke down and ulcerated, and finally disappeared when the mixed treatment was given, and iodoform applied locally.

Dr. ALLEN said that in this case the cauliflower-like eruption formed exuberant granulations, which did not cause so much destruction as in other forms of syphilitic lesions.

---

## Correspondence.

---

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

#### The Pathogeny of Dermatoses.

IN beginning this letter, I cannot resist the inclination to indicate in a few words the great importance of the new chemical researches of M. Gautier (presented before the Paris Academy of Medicine, Jan. 19, 1886), in their bearing upon the pathogeny of diseases in general, and of diseases of the skin in particular. For some time past, I have already, in several articles, expressed myself in accord with my friend, Dr. Barthélemy, that the explanation of many dermatoses of obscure origin was furnished us by the eruptions which develop after the ingestion of certain substances, especially the medicaments. In the latter case, it must be admitted that the noxious foreign element, after having been absorbed and taken up in the circulatory current, goes to act either upon the nervous system or directly upon the integument, and develops an eruption quite characteristic in the majority of cases, for the noxious substance is promptly eliminated. We in-

sist that it would be quite logical to admit the same pathogeny for a large class of eruptions, especially for rebellious and recurrent eczemas, which are so frequently observed in certain persons, especially the gouty.

We believe that they are caused by the accumulation in the blood of these patients of the products of incomplete assimilation, tending to the impoverishment of their nutrition, products which must of necessity be injurious to the organism.

The researches of M. Gautier confirm our theory in a novel manner. For some time we have known that after death there are produced in the cadaver toxic alkaloids, to which are given the name of ptomaines. M. Gautier has demonstrated that in our organism, even during life, there are likewise produced alkaloids more or less toxic, more or less injurious, to which he has given the name of leucomaines, and which, when not destroyed by the oxygen of the blood or eliminated either by the kidneys or alimentary canal, may, by thus accumulating in the economy, occasion morbid phenomena. Let any cause whatever, then, hinder hematosiis, diminish the oxidating power of the hematics, interfere with the eliminating action of the various emunctories of the body, and soon the blood, surcharged with toxic principles, will find itself, in relation to the skin, precisely in the same condition as if it had been vitiated by the ingestion of a medicinal substance capable of promoting an artificial eruption.

For my part, I have come to the conclusion that, from the point of view of this pathogeny, the diseases of the skin of actually known origin may be divided in four grand classes.

1. Artificial eruptions from mechanical, external cause, or eruptions directly provoked.
2. Artificial eruptions from internal cause or provoked indirectly—the pathogenetic affections of Bazin—resulting from the ingestion of alimentary or noxious medicamentous substances.
3. Eruptions depending upon the vitiation of the blood and of the entire economy by the leucomaines.
4. Eruptions of parasitic nature, animal or vegetable parasites and microbes, bacilli in particular.

I do not believe, as one of our savant professors asserted before the Academy of Medicine, that the discovery of leucomaines will prove to be the death-blow of microbian theories; I believe that the two discoveries complement each other. It is not possible to explain all by the microbes alone, or by the leucomaines alone. But in admitting the reality of these two grand causes of disease, the pathogeny of nearly all diseases seems to us clear, logical, rational, established upon a basis almost impregnable.

### Eczema in the Gouty.

I am all the more disposed to admit that the leucomaines or other products, of whatever nature they may be, morbidly found in the economy, intervene in the pathogeny of certain dermatoses, since, faithful to the old French doctrines of Hospital St. Louis, I have always believed and always contended that the diseases of the skin could not in all cases be considered as purely local lesions. On this account, I cannot too highly approve of the recent communication of Dr. Deligny upon Eczema of the Gouty (*Union Médicale*). He there shows that there exist incontestable relations between certain dermatoses and certain general states, especially of an arthritic nature. He has observed distinct alternations between

cutaneous eruptions and visceral phenomena, bronchitis, attacks of articular gout, neuralgias, attacks of asthma, etc. . . . He has, moreover, observed that eczema in the gouty does not become tenacious, chronic, rebellious to local medication, until the period of life when these patients begin to present evidences of dyspeptic trouble, that is, from 25 to 35 years of age. Now it is quite pertinent to inquire if the incomplete digestion does not facilitate the production in the organism of the noxious elements of which I have already spoken.

Abandoning now these questions of pathogeny as, perhaps, somewhat too abstract at first glance, but which, nevertheless, are of the greatest practical importance, since the rational treatment of these rebellious dermatoses depends upon their correct understanding, we may say that, according to Dr. Deligny, eczema of the gouty resembles eczema of the rheumatics; the lesions are dry, rarely exudative, squamous, circumscribed, especially affecting the discoid or orbicular form. It is much oftener observed in men than in women; it is situated especially upon the head (face and hairy scalp in nine of thirty-six cases), and at the anus (in thirteen of thirty-six cases). He thinks that its frequency in this latter region should be attributed to the anal pruritus so common in these patients, to the scratching which it occasions and to the irritant applications which are continually applied for its relief.

As to treatment, Dr. Deligny is quite pronounced. According to his experience, which embraces about one hundred and forty cases of gouty eczema, he believes that alkaline medication gives by far the best results. It is quite otherwise, he adds, in the case of eczema occurring in rheumatics; in this class of patients alkalies often fail. It is not, then, a matter of indifference whether a gouty patient with eczema is sent to an alkaline or to a sulphurous mineral spring. There are cases in which irritability of the skin or other individual conditions will not admit of the employment of fresh alkaline mineral waters; it is then necessary to have recourse to chlorinated sulphur waters.

### Treatment of Psoriasis with Chrysophanic Acid.

Drs. du Cazal and Boutonnier have recently published two articles (*Archives de Médecine et de Pharmacie Militaire*) upon the treatment of psoriasis by chrysophanic acid, which they employ either in ointment, according to the older method, or in solution in chloroform, after Besnier's process. This last method consists, as indicated in a previous letter, in scraping off the scales in a bath, then painting the patches with a fifteen-per-cent solution of chrysophanic acid in chloroform, and covering them with a layer of traumaticine. These applications are made every second or third day. By this mode of treatment they succeed in causing the disease to disappear in from fifteen days to five weeks. The results are by no means unusual, and I should not have referred to these articles had they not contained an opinion which appears most surprising. Having never observed a recurrence of the disease after the chrysophanic acid treatment, these authors conclude that this dermatosis should not be regarded as a rebellious disease, and should not be the occasion of a reduction in the regiments, and of exemption before the councils of revision. Certainly there are, in my opinion, patients with psoriasis who may well be retained in the military service, but I cannot accept the statement that by chrysophanic acid treatment psoriasis may be regarded as a tractable and curable disease. Psoriasis is, on the contrary, it hardly need be said, the recurrent dermatosis *par excellence*. There are patients who have only a single crop of eruption, but how much more numerous are those in whom it re-



establishes itself with the greatest tenacity. Experience has long since demonstrated that we cannot regard a psoriatic patient as cured when we have simply cleared the surface, whatever may have been the method of treatment employed. In my experience with chrysophanic acid in psoriasis, I have been especially impressed with the variability of the results obtained in different cases, which, no doubt, depend partly upon individual susceptibilities, and partly upon the quality of the chrysarobin. Sometimes this agent acts most energetically in small doses, sometimes it develops a most intense erythematous eruption, sometimes it appears almost inert. I have often seen recurrences in patients whose skin has been perfectly cleared by this treatment. At the present time, we possess many agents (goudron, naphthol, oil of cade, pyrogallic and chrysophanic acids) and many therapeutical processes (ointments, traumaticine, medicated collodions, with addition of salicylic acid, etc.), which are really efficacious in causing the disappearance of the psoriatic patches, but which are powerless against their return. Arsenic and arsenical waters seem to be the best, or the least objectionable, means we can employ for this purpose; but they are far from being infallible. The more I observe the course of this disease, the more I am convinced that it should not be considered a purely local affection of parasitic nature, as Drs. Lang and du Cazal contend. I believe that, like certain eczemas, it is in the large majority of cases an external manifestation of a constitutional state of certain predisposed individuals, and I am persuaded that dermatologists should seek to find a radical cure, if this be possible, in an internal treatment, with appropriate regimen.

### Vulvar Pruritus.

Dr. Martineau has published a lecture (*Annales Médico-Chirurgicales*) upon vulvar pruritus, in which he gives to practitioners certain advice in regard to the best mode of treatment of this painful and rebellious affection. First of all, it is important to ascertain the cause of the disease; for, in order to treat it intelligently, it is necessary: 1st, to treat the constitutional malady, the original source of the accident; 2d, to treat the lesion, the immediate cause of the pruritus; 3d, to treat the morbid phenomenon, the pruritus. We should determine whether the patient is tuberculous, lymphatic, neuropathic, arthritic, diabetic, etc.; then, whether there exists any parasitic affection, as intestinal worms, oxyures, pediculi pudendi, herpes tonsurans; whether there are vesical or urethral disorders, etc.; and the genital organs should be carefully examined, the vulva, vagina, and uterus, since vulvar pruritus is often symptomatic of metritis, of vaginitis, of contagious vulvitis, or it may be consecutive to eruptions of psoriasis, lichen, zona, and especially herpes. Finally, vulvar pruritus may be purely of nervous origin, and occur without any apparent lesion of the integument; in nervous or arthritic women, any moral impression, or simple change of temperature, may suffice to develop it.

After this preliminary, but quite necessary investigation, one is prepared to treat the pruritus intelligently and successfully. A treatment appropriate to the constitutional condition and the local lesion may then be instituted, although, as intimated above, we must rely upon local means to palliate the almost intolerable intensity of the morbid phenomenon. When there is an acute inflammation, as in vulvitis, emollients, poultices of potato starch, lotions with infusions of belladonna, aconite, or poppy heads should be employed, or a solution of bromide of potassium or chloral. Dr. Martineau recommends that the lotions be applied rather warm than cold. The poultices may be replaced by compresses of

fine linen saturated with a decoction of leaves of elder or myrrh. When the acute stage has subsided, weak lotions of the sublimate may be employed, two or three times a day. Sometimes slight cauterization with nitrate of silver will be found serviceable; sometimes the application to the vulva of compresses dipped in a slightly acidulated water affords relief. At night, if there is irritation of the integument, it may be smeared over with an ointment composed of 50 grams of glycerole of starch to 1 gram of either tannin, calomel, ext. belladonna or oil of cade, according to circumstances.

In chronic cases, Dr. N. Guéneau de Mussy makes lotions with the following: Infusion of marsh mallow, 1 litre; cherry-laurel water, 50 grams; subborate of soda, 10 grams. He then prescribes an ointment to be used night and morning, as follows: Glycerole of starch, 20 grams; bromide of potassium and subnitrate of bismuth,  $\frac{1}{2}$  gram; calomel, 40 centigrams; extract of belladonna, 20 centigrams.

Delieux de Savignac uses the above lotion, and then dusts the surface with the following powder: Pulv. lycopodium, 30 grams; subnitrate of bismuth, 19 grams; belladonna root, 2 grams. Sometimes good results are obtained by sprinkling the vulva with iodoform.

Since the discovery of cocaine, it has been employed in all painful affections of the mucous membranes, and especially in vulvar pruritus. Dujardin Beaumetz has been able to obtain a prompt anæsthesia of the vulva by painting the parts with a one-fiftieth solution of this drug. In my experience, I have found that an almost intolerable pruritus, symptomatic of herpes of the vulva, may be relieved by applications of an ointment of cocaine ( $\frac{1}{16}$  to  $\frac{1}{15}$ ).

### Treatment of Gonorrhœa with Antiseptic Injections.

Dr. A. Bourgeois has recently published (*Archives de Médecine et de Pharmacie Militaires*) an important article on the treatment of gonorrhœa with antiseptic injections. Since the microbiologists have affirmed the existence of a gonococcal cause of gonorrhœa, the whole problem, in the author's opinion, consists in finding an antiparasitic topic, sufficiently energetic, but innocuous to the mucous membrane. It is thus necessary to lay aside all very irritating substances; the three parasitocides which seem to him to unite all required conditions are permanganate of potash, bichloride of mercury, and sulphate of quinine. He employs the permanganate in solution (1 to 2,000), the bichloride (1 to 20,000), the sulphate of quinine (1 to 100). Four injections are to be made in twenty-four hours, one in the morning, one at noon, one at seven o'clock in the evening, and the other during the night; this last is indispensable, according to Dr. Bourgeois since, if the microbes be left to repose during the entire night, they will have time to multiply. The injection should be warm, as it thus penetrates more easily into the urethra; it should not occasion pain; if so, it should be diluted until it can be well tolerated. A glass syringe, well graduated, capacity of eight grams, should be used. The injection should be made to entirely fill the urethra, but not to forcibly distend it and produce pain and perhaps injury to the mucous membrane. It is much better to use colored liquids, since one can thus better judge of the quantity introduced into the urethra. After having diluted the first injections, the patient will gradually get accustomed to the full strength recommended above. The patient should be directed to urinate one-quarter of an hour before, and as long as possible after the injection.

In order to insure the penetration of the medicated liquid to the desired depth,

Dr. Bourgeois has devised another procedure, which consists in introducing within the urethra, to the depth of about eight centimetres, a cylindrical gum sound of medium calibre, open at its two extremities, without lateral eyes. This is first smeared with iodoform ointment (1 to 20), and a glass syringe, holding eight grammes of the injection, is filled to its free extremity, and the liquid is gently forced into the urethra, the instrument being at the same time gradually withdrawn, so that the liquid replaces the sound in the canal, where it is retained from ten to fifteen minutes. Two or three such operations should be made in the course of twenty-four hours. In addition, the author gives to his patients, during the entire course of the disease, one to two grams per day of bromide of potassium, with a view of preventing all genesic excitement. He also treats the constitutional condition of his patients with appropriate medication.

### Gastric Syphilis.—Rickets and Hereditary Syphilis.

Among the numerous interesting publications which have recently appeared in France upon syphilis, I may direct the attention of your readers to two mémoires of Dr. Gaillard, one of which refers to the possibility of the occurrence of ulcerous lesions of the stomach, of syphilitic origin, and consequently curable by mixed treatment (*Archives Générales de Médecine*, Jan., 1866); the other in which he shows, by the most convincing facts, that rickets may be considered, as claimed by Parrot, one of the manifestations of hereditary syphilis (*France Médicale*, Jan. 7, 1866).

L. BROCCQ.

PARIS.

## Selections.

### THE CONTAGIUM OF SYPHILIS.

A PRACTICALLY complete series of experiments on the carrier of the contagion of syphilis will be published in the transactions of the *Tokio Daigaku*.

The most important results arrived at by the authors, Dr. Disse and Dr. Taguchi, are here given.

1. In the blood of syphilitic individuals are found spores, which can be demonstrated in specimens of blood from the living person, stained with the necessary precautions, dried on a cover glass, and preserved for a time in absolute alcohol. For the most part, the staining method of Gram is recommended (*Fortschritte der Medicin*, Bd. 2, 1885).

2. In the secretion of flat condylomata, as also in the primary induration, the spores are found altogether similar, and numerous short bacilli are also present, which are made visible by the same method as the spores in the blood.

3. In the blood of syphilitics, under treatment for secondary symptoms, are found bacilli as well as spores, partly in the leucocytes.

4. If you introduce a small quantity of fresh blood, drawn with all necessary precautions from a syphilitic individual, into a solid culture field (culture gelatin peptonized broth with agar-agar, blood serum), there develops within a few days, at a temperature ranging from 18 to 40° Celsius, a pure culture of peculiar bacilli, which actively form spores.

5. In neutralized meat broth, it is observed that these bacilli show extraordinary active movements at a temperature of 32°, and slower movements at a temperature of 16° Celsius. Here also is to be seen the capsule, which, in stained preparations from culture gelatin and blood serum is not so easily discernible. In their movements, the bacilli often become curved or bent, and those containing spores often take on the appearance of heaped up micrococci. In hanging drops of meat broth, the bacilli remain at the summer temperature of Tokio (about 30° Celsius during the months of July and August), for five days and longer full of life and motion.

6. From the blood of a cadaver, on which were found signs of syphilis, the same cultures were obtained as from the blood of living syphilitic subjects. A pure culture was obtained, twenty-seven hours after death, from a specimen of blood taken from a vein of the brain.

7. Blood serum does not become fluid from a culture with syphilitic blood. The culture forms a whitish thread following the inoculation, which quickly spreads over the free surface of the culture field in the form of a white coating. Cultures in gelatin or broth peptone with agar-agar will become fluid after a few days in the neighborhood of the inoculation, spreading out from the surface.

8. Kept in the room in Japan, during the summer months, the cultures develop as rapidly as in the culture oven.

9. A culture in blood-serum was found entirely active after four months.

10. Inoculation with such pure cultures will infect rabbits, white mice, dogs, sheep, etc.

11. At the point of inoculation there is a slight induration, which, however, does not inflame. In one case (rabbit), the induration became as large as a pea, remained from eight to sixteen days, and then gradually disappeared. In the blood of all the inoculated animals were found spores and bacilli, and spores in process of formation. In every case, the spores resembled those of the culture used.

The quantity of micro-organisms was proportionate to the time which had elapsed since the inoculation. At first, the spores and bacilli were free; later, they were found in the white and red blood-corpuscles.

12. From the blood of the inoculated animals, pure cultures were made, which resembled in all cases those obtained from the blood of syphilitic men.

13. Inoculation with cultures from the blood of inoculated animals was followed by the same results as those from the human-blood cultures.

14. In a pregnant rabbit, killed two months after inoculation with a culture from human blood, the blood of the foetus, carried almost to term, was found filled with the same bacilli and spores as the mother's blood. A portion of the bacilli were inclosed in the leucocytes.

15. In the mucous membrane of the uterus of the rabbit referred to, was found one large (30 millimetres long and 20 millimetres broad) and several smaller, white, prominent nodules of a round form, which were found to be principally made up of a cheesy mass in which many necrotic cells were still to be seen. The mucous membrane and glands were entirely destroyed in these masses, and only a few blood-vessels could be found in the detritus.

In the placenta was found a yellowish-white nodule measuring 12 by 9 millimetres, and 5 millimetres thick, proceeding from the chorion, and attached to the foetal side of the placenta. The cheesy mass of which it was made up contained here and there groups of cells, which resembled decidual cells. All the placentas were diffusely affected.



16. In the livers of the rabbit mentioned, and of one other likewise killed after two months, several gummata were found, some as large as a pea. In the bronchus of one, there was a cheesy nodule proceeding from the mucous membrane. There was no tubercular deposit.

17. In the gummata of the liver, as well as in the cheesy nodules of the mucous membrane and of the placenta, were found a few bacilli and spores which resembled those of the blood. These were at once brought out by staining the section after Gram's method.

18. Aside from a slight loss of flesh, the inoculated animals showed no signs of sickness. The most of them (dogs, sheep, and several rabbits) are still under observation. On October 12, a rabbit died which had been inoculated on June 2. The post-mortem showed syphilis of the lungs, stomach, and skull. The observations were begun in March, 1885. As the first cultures and inoculations were made, we received an account of the observations of Lustgarten (*Lancet*, April 4, 1885).

As, up to the present time, the larger illustrated work prepared by this author has not been received, we are not prepared to say whether the bacilli found by us are the same as those Lustgarten discovered in the products of syphilis in the human subject.—*Deutsche Med. Wochenschrift*, No. 48, 1885.

### DIFFERENTIAL DIAGNOSIS OF SYPHILIS AND SCROFULA.

IN syphilis all is change and variety; in scrofula all is fixed and immutable. The cutaneous lesions of syphilis are migrating; the lesions of scrofula are riveted, so to speak, in their primary place which they never quit; and this fixity of situation, during a prolonged period, often many years in duration, will suffice to distinguish them from the *syphilides*, which are ambulatory, and which appear in successive crops and upon different regions of the body.

The lesions of syphilis are *intermittent* in duration; the lesions of scrofula are essentially *permanent*, and this absolute *continuity* during five, ten, fifteen years will suffice again to distinguish them from syphilides, which appear and disappear at intervals more or less distant.

Syphilis is a Proteus; it manifests itself upon the skin by the most diverse lesions; in the same patient, at different periods of its evolution, it presents the most different aspects, because the lesions which represent it are most numerous and diverse. In scrofula, on the contrary, it is always the same lesion; there is only one form one day to another.

In syphilis we have, then, *variety of situation, variety of duration, variety of lesions*; in scrofula, *fixity of situation, fixity of duration, fixity of lesions*.

Syphilis has its special coloration, a deep-reddish brown; scrofula its also, a light raspberry-red; vinous tints disposed in large, prominent, and neatly limited patches.

Syphilitic lesions develop over the entire surface of the body, it does not spare any region; the lesions of scrofula are rarely found except upon the face, and particularly upon the nose and cheeks; they scarcely ever descend below the neck.

Syphilis is hereditary, virulent, inoculable, and contagious by direct contact; scrofula is likewise hereditary, but it is neither virulent nor contagious by direct contact and inoculation.

Syphilis affects all ages, all temperaments, all constitutions; scrofula rarely develops before the fourth or fifth year; and in order to develop, there is necessary a special *terrain*, a particular constitution, a *scrofulous temperament*. This

temperament is revealed by certain special characteristics: the head disproportionate in size to the rest of the body; alæ of the nose thickened; nose flattened, large; nostrils incrustated; eyes bleared; mouth widely slit; lips thick; the transverse diameter of the face larger than the vertical; neck voluminous and as if engorged; legs short; the *ensemble* of the body without harmony, ungraceful; intelligence slightly developed.

The lesions of scrofula are not more painful than those of syphilis; but while the syphilides are ordinarily accompanied with slight fever and constitutional disturbance, the severest lesions of scrofula occasion no disorder in the physiological exercise of the animal functions.

The syphilitic ulcer is regular in contour, as if punched out; the scrofulous ulcer is irregular, its edges are jagged and detached.

In its work of destruction, syphilis proceeds from the deep to the superficial parts: scrofula follows an inverse course; it begins by destroying the skin before destroying the cartilages and bones.

Scrofula in its period of development, and when stationary, always produces hypertrophy of the parts which it involves: and in its period of decline it atrophies the same parts; it leaves the nose sharpened, lanceolate, and the opening of the nostrils retracted and obliterated. When scrofula gets well, it is followed by hideous deformities, always irremediable. The cicatrices of all its lesions are indelible, like those of syphilis; but while the latter are pale, colorless, smooth, and not adherent to the parts beneath, the cicatrices of scrofula are, on the contrary, irregularly violaceous, reticulated, seamed, anfractuous, and intimately adherent to the subjacent tissues.

All the scrofulides are *malignant* lesions; they all disorganize the skin in different degrees, and often destroy the organs and the bones. Their duration is always essentially chronic.—M. GUIBOUT, *Gazette des Hôpitaux*, No. 74, 1885.

### TUBERCULOSIS VERRUCOSA CUTIS.

It is only in very recent times that tuberculosis of the skin has been studied, and as yet but few cases have been reported. Drs. Riehl and Paltauf (*Vierteljahr. für Derm. und Syph.*, 1886, xiii., 19) now designate with the above title an, as yet, underscribed form of the disease, as they claim. This study is upon a number of cases seen in Kaposi's wards in Vienna. The disease attacks persons of both sexes, but especially men; is found on the back of one or both hands, sometimes on the flexor surfaces of the fingers or between the fingers, rarely on the palms or adjacent parts of the forearm. It occurs in patches, varying in size from that of a lentil to that of a silver fifty-cent piece; in shape either round or oval, or serpiginous when several join at their edges. These enlarge at their peripheries by the deposition of new primary lesions, so that in all patches of old standing the edge will present the appearances of the primary efflorescences, while the central part will be at its height or undergoing resolution. A developing patch will be surrounded by an outer erythematous band a few millimetres wide, of a bright-red color, which disappears fully under pressure, and is scarcely raised above the *niveau* excepting on its inner part. It is smooth and often glossy, with the mouths of the glands and follicles plainly recognizable. Inside of this band there is often another zone composed of small lentil to hemp-seed superficial disseminated pustules with thin covers, or of numerous crusts or scales, remnants of the same. This zone is brownish or livid-red in color, which passes under pressure with a yellowish tinge, showing the presence of infiltration

Nearer the centre the surface of the patch becomes more raised, and irregularly uneven, the unevenness increasing centrally into warty growths with club-shaped or more pointed ends—papillomas, some of which are five to seven mm. high. The surface of this central part is generally covered with crusts. Between the papillomas are rhagades, small erosions, or pustules, and when the patch is squeezed numerous drops of pus escape from between the warty excrescences. The patches are occasionally acutely inflamed. This is the height of the affection.

Retrogression is shown by a flattening of the papillomas toward the middle of the patch, a lessening of the crusting, and disappearance of the little abscesses. In very old patches the centre is even, has no papillomas, is smooth, or slightly scaly, or of cicatricial appearance. The cicatrices are located chiefly in the papillary layer of the skin; are thin and supple, and have a sieve-like or fine net-form appearance.

The only subjective symptom is a feeling of pressure during the developmental stage of the disease, which sometimes on contact increases to a feeling of pain. The subjects of the disease all were more or less occupied in caring for animals or handling meat.

The disease is chronic, advances slowly, and apparently is unlimited in its growth. A patch will be at its height one or two months before the papillomas begin to flatten.

The *diagnosis* is made upon the course of the disease as a whole, rather than upon any particular characteristic symptom. It differs from *lupus* in not having brown-red nodules, and in its advance being accompanied by inflammatory symptoms; in showing no tendency to ulceration, nor to return in its cicatrices. While *lupus* hardly ever occurs after puberty, this form of tuberculosis occurs after puberty. It differs from *simple inflammatory papillomas* in not being so inflammatory, and in being slow in development. From *frambæsiiform syphilis*, it is diagnosed by the absence of the hard, brown-red infiltration of its edge, and by its history.

*Histologically*, the disease presents in its infiltration the peculiarities of giant-cell tubercular infiltration. Tubercle bacilli were also found in the giant cells and in other places.

The *prognosis* is good when properly treated. The *treatment* consists either in excision or curetting, followed by cauterization. They found curetting followed by application of caustic potash, or silver nitrate, or in combination with iodoform dressing, the best method of treatment. The galvano-cautery is also a good method of treatment.

### CONTRIBUTION TO THE STUDY OF THE PATHOGENY OF HERPES PHLYCTÆNOIDES.

THE eruptions of phlyctænoid vesicles, commonly called *herpes phlyctænoides*, appear to form two categories.

The one, which we shall call *microbic herpes* is produced by the elimination through the skin of micro-organisms, either non-pyogenic or but slightly so.

This category includes *black herpes*—a variety which has points of resemblance with *zona* (Erb, Landouzy). You can also place alongside of this variety the vesiculations of *variola*, of malignant pustule, and of *erysipelas*.

This variety of herpes, which could also be called *septic herpes*, appears to be caused by a microbic infection, of which the particular infecting agent is un-

known to us, the production of a cutaneous or mucous vesicle being but an epiphenomenon of a severe general morbid state.

The second category of herpes phlyctænoides includes *ptomainic herpes* (Boucheron), which has as immediate cause the determination to the skin or the mucous membrane of materials of the nature of animal alkaloids, or vesicating *zoamines*.

This herpes can appear under a great number of circumstances. It may be, for example, a sequence of irregularities of regime, of muscular or nervous overwork, of violent emotion, and of certain menstrual states. It may also appear in those undetermined conditions which correspond to the general morbid state clinically called *herpetic* or *arthritic*.

a. In a predisposed individual, an irregularity of digestion may be followed, in thirty-six or forty-eight hours, by an herpetic vesication affecting some region of the skin or of the mucous membrane. We believe that in this case the alimentary materials taken in excess not having been sufficiently elaborated or oxydized, there has resulted a series of residues—some well known, as, for example, uric acid; others with which we are not sufficiently acquainted, as the ptomaines and alkaloids, substances of which the nature is, from a chemical point of view, to be irritant in a high degree. Insufficiently expelled by the normal channels of elimination, these substances find themselves, at a given moment, in too great quantity in the blood, and take an abnormal course of elimination, thus causing vesicles of herpes.

b. Herpes following muscular or nervous overwork results equally in an excessive production of organic waste products which the natural emunctories are not able to eliminate, and which seek an exit by the way of the mucous membranes.

c. In herpes produced by emotional shock or by cold, there are in addition inhibitory phenomena (Brown-Sequard), or arrest of elimination of waste products by the natural channels, which likewise seek abnormal ones.

d. Menstruation, having besides its physiological function the pathological one of elimination of materials in excess in the organism, it can, when arrested, give rise to a variety of disturbances, among which herpes may be observed.

e. All the causes above enumerated play only an incidental rôle, the determining cause being the arthritic state of the individual. Arthritic subjects—that is to say, those having the pathological conditions necessary to the production of vesicating material, should :—

1. By a dietetic régime suitable to their case avoid the production of these vesicating substances in excess.

2. By following hygienic laws and therapeutic measures, favor the elimination of vesicating substances by the natural emunctories.—*Th. de Paris*.

### LEUCODERMA SYPHILITICUM.

*Nordiskt Medicinskt Arkiv*, vol. xvii., number 3, contains an article of thirty-one pages on syphilitic leucoderma, by Dr. Alex. Haslund, Visiting Physician to the City Hospital of Copenhagen, Denmark. With special regard to this disease, the author examined all patients admitted to the Hospital during four months. Of 83 men, 25, or 30.1 per cent, had leucoderma; of 122 women, 80 had it. The disease is characterized by the light-colored round spots. The intervening skin may be normal, but is often the seat of a dark pigmentation. The latter can be made to fade by means of bichloride of mercury, but there is no remedy for the light spots. The affection is very chronic, and may last for years. They are decidedly of syphilitic origin. Each spot appears only where there has been a



macular syphilide. He has never seen them after papular eruption. The white spots sometimes found after papular syphilides are only the remnants of the papules themselves, quite level, white cicatrices due to a real change in the tissue of the skin, whereas in leucoderma the skin is normal, only deprived of pigment.

The diagnosis is easy.

The affection is not a symptom of syphilis, but a sign that the individual has had macular syphilides.

Of the 25 men, 5 only had occupations in which they often were exposed to fire, 13 had dark hair, 12 were blonde.

Of the 80 women, 37 had dark hair, and 43 light hair. Thus, neither exposure to irradiating heat, nor the color of the skin, as claimed by some authors, seems to have any influence in the production of leucoderma.

### HEMORRHAGES IN SYPHILIS.

THE following are the conclusions reached by Drs. Hartmann and Pignot from a study of hemorrhages in syphilis (*Annales de Dermat. et de Syphilig.*, January, 1886).

A. In congenital syphilis a true hemorrhagic diathesis is observed.

B. In acquired syphilis

1. Nothing proves that the diathesis exercises its influence upon the production of hemorrhages on the surface of simple wounds.

2. Even in the cases where the cutting instrument encounters tissues altered by the disease itself, serious hemorrhage is exceptional.

3. Specific ulcerations simply give rise to slight oozing of blood. Those cases must be excepted in which, by an extension of the morbid process, an important vascular branch is destroyed.

4. By the intervention of an arteritis which it produces, syphilis may be the cause of visceral hemorrhages, especially in the brain. The paroxysmal form of hæmoglobinuria frequently has syphilis as a cause.

According to Murri, the changes are explained by a morbid state affecting at the same time the organs producing the globules and the vaso-motor centres.

5. Syphilis may determine cutaneous hemorrhages, *a*, on the surface of specific eruptions; *b*, in producing a special form of purpura; *c*, in acting as a determining cause of a purpura presenting its usual characters, but appearing in the period of secondary syphilis.

### CONTRIBUTION TO THE STUDY OF ZOSTER FEVER, INFECTIOUS ZONA.

1. THE distinction must be made between zoster and zosteriform eruptions.

2. Zoster is an acute febrile disease.

3. This affection, by reason of its evolution and of a certain degree of contagiousness and tendency to exist epidemically, should be classed among the general infectious diseases.

4. The localization of the eruption on the course of a nerve, and the lesion of the nerve ganglia lead to the belief that the affection is a neuropathy.

5. This ganglionic neuropathy is probably due to the presence of a specific micro-organism.

6. The etiology, the evolution, and the unity of zoster separate, in a marked and well-defined way, this affection from diseases having similar vesicular eruptions—the zoster-like exanthemata and herpetic fever. — DR. L. BOULANGER, *Th. de Paris*, 1885.

## Books and Pamphlets Received.

Lehrbuch der Haut- und Geschlechtskrankheiten für Studierende und Aerzte, von DR. EDMUND LESSER, Privat-Docent an der Universität Leipzig. Will be noticed in subsequent number.

Le la Sarcomatose Cutanée, par DOCTEUR LEON PERRIN, Ancien Interne en Médecine et en chirurgie des Hôpitaux de Paris. Will be noticed in subsequent number.

La Lèpre doit-elle être Considérée comme une Affection Contagieuse, par le DR. BROCCQ. Reprint.

Ein Fall von Ringelhaaren, von DR. EDMUND LESSER. Reprint.

Ein Fall von Lichen Planus chronicus trunci et extremitatum, von DR. C. SCHADECK. Reprint.

Ein Fall von Leucoderma Syphiliticum, von DR. C. SCHADECK. Reprint.

Zur Casuistik des Herpes iris universalis, von DR. C. SCHADECK. Reprint.

Zur Casuistik der syphilitischen Erkrankungen des Nebenhodens, von DR. C. SCHADECK. Reprint.

On the Affections of the Skin Induced by Temperature Variations in Cold Weather, by DR. J. NEVINS HYDE. Reprint.

Alopecia Areata: its Etiology, Diagnosis, and Treatment, by GEORGE THOMAS JACKSON, M.D. Reprint.

The Nervous Symptoms of So-called Lithæmia, by LANDON CARTER GRAY, M.D. Reprint.

The Third Annual Report of the New York Skin and Cancer Hospital shows this institution to be in a flourishing condition. It appears that 1,064 patients have been treated since the last annual report. About 140 of these were cancer. In addition to the City Hospital, this institution has a country branch of cottage pavilions, just opened at Fordham Heights. This Charity is doing a noble work, and merits the confidence and support of the profession and the public.

---

## Items.

**OINTMENT FOR SYPHILITIC PSORIASIS.**—Mauriac recommends, as a local application in syphilitic eruptions on the palms and soles :

R Ol. cadini,

Ung. hydrargyri.....āā 3 ss.

Vaseline..... 3 i.

**COPAIBA SUPPOSITORIES IN VAGINITIS.**—The *Bulletin Gén. de Thérapeutique* says Prof. Ball has successfully treated acute inflammation of the vagina with suppositories of seventy-five grains of copaiba and cocoa butter, and three-fourths of a grain of opium. The suppositories are allowed to remain twelve hours. In twenty days the patients are entirely cured.

**POISON IVY ERUPTION.**—An excellent remedy is said to be an infusion of the sweet fern (*Comptonia Asplenifolia*). This is rubbed freely all over the affected surface, and left to dry. The slightly yellowish stain left by its application wears off in a few days.—*Exchange*.

# JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

JUNE, 1886.

No. 6.

---

## Original Communications.

---

### SOME REMARKS ON THE DIAGNOSIS AND TREATMENT OF SPASMODIC STRICTURE.

BY

JOHN BLAKE WHITE, M.D.,  
Physician to Charity Hospital.

ORGANIC strictures of the deep urethra are very rarely met with, as all surgeons assure us, but contractions dependent upon irritation reflected from the anterior canal are of common occurrence. The presence of a stricture in the pendulous urethra, or the existence even of a contracted meatus urinarius, often occasions, as a result of reflex irritation, a contraction at the membranous junction so resistant that a filiform bougie cannot be passed beyond it.

Such spasmodic action of the muscular urethra may result from other causes than the existence of organic strictures in the anterior urethra. A spasm is occasionally produced in the membranous portion by the simple passage of an instrument along the urethra, which acts solely as an irritating medium to the mucous membrane, precisely as an irritation may be occasioned by highly acid urine.

Voluntary retention of urine for a prolonged period is also capable of exciting spasm. Diseases of the rectum and all irritations about the anus, as well as derangements of the digestive or cerebro-spinal system, may produce urethral spasm.

A slight urethral discharge is, generally, an early and constant symptom of stricture. Such a urethral discharge might arise from causes independent of stricture, but the continued presence of a gleet may be

justly regarded as symptomatic of a contraction in some part of the urethra.

Among other important symptoms of stricture may be mentioned a more or less frequent desire to urinate, associated with lumbar pain, sometimes extending from the back around both sides to the inguinal regions and down the scrotum, following the course of both ureters and the spermatic cord. Pain is also referred, occasionally, to the suprapubic region, or in the perineum and along the urethra before, during, or after urination.

A sharp pain is not infrequently experienced at the end of the penis after the bladder has been emptied. This is, I think, oftener observed when a spasmodic condition of the membranous urethra exists, or rather has a tendency to be excited to spasm as the result of a permanent stricture anterior to the bulb.

The stream of water is more or less altered in size, momentum, and form. It may assume a spiral shape, may be expelled from the meatus in two or more distinct streams, or the patient may be obliged to make strenuous efforts to urinate, without avail. This symptom is more likely to be present when permanent strictures complicate the spasmodic, but the symptom may also be an indication of the latter condition alone.

When urine manifests an ammoniacal condition, the presence of stricture may be suspected. A partial retention of the urine is thus occasioned by the incomplete emptying of the bladder, and the retained portion is prone to decompose, thus exciting troublesome cystitis if the obstruction is not removed promptly.

Prof. F. N. Otis has often demonstrated the frequency with which strictures of the deep urethra are found to co-exist with a contracted meatus urinarius only. They have been shown to be dependent not infrequently upon the presence of strictures of large or small calibre in the penile urethra. No surgeon merits more credit than Prof. Otis for recognizing and proving the correctness of these facts by the results of many such operations for the relief of spasmodic strictures.

In the course of my experience I have met with not a few instances where a contracted orifice or stricture of large calibre situated in the penile urethra was the sole cause of what seemed to be an impassable stricture of the deeper portions of the urethra.

Some eminent surgeons believe that, in accounting for deep strictures, the possible influence of spasm as an exciting cause does not as frequently obtain as is claimed. My personal observations and experience have led me to think differently. The reflex character of such deep strictures is not so often recognized as its importance and frequent influence demand.



The two following cases will afford good examples of the subject under discussion :

CASE I.—Julius A., aged 24 ; single. Has had repeated attacks of gonorrhœa, the last occurring about six months ago (October, 1885). At the time the patient was seen, there was some slight urethral discharge. Complained of pain on urination along the urethra and especially at the end of the penis. Passes a very small stream of water, with some effort at times.

Upon examination, the circumference of the penis measured three and one-half inches. The calibre of the urethra should therefore be 34 F. to represent the normal proportionate relation as advised by Dr. Otis. At an inch and a half from the meatus there was a stricture of 14 F. and one also at three inches of 10 F. The meatus itself was 24 F. In the deep urethra a stricture was discovered which resisted the passage of a filiform bougie. It was thought that the deep stricture was of reflex origin. Dr. Otis, who was invited to see the case, was of the same opinion, and advised the division of the anterior strictures with the meatus to 34 F., which was performed. The operation confirmed the diagnosis concerning the deep stricture, as a 34 F. sound was readily passed into the bladder. The patient convalesced rapidly and satisfactorily.

CASE II.—Frank R., aged 26, single. Has had several attacks of gonorrhœa. After the last attack he experienced some pain on micturition, especially over the suprapubic region and at the extremity of the penis. Sometimes he had difficulty in passing water, being obliged to make an expulsive effort to do so, and afterwards for a little while the urine would dribble away. He had found it impossible sometimes to urinate at the time he felt the inclination to do so, but never had retention, so that instrumentation became a necessary resort for relief. Has been suffering from a gleet discharge for a long while, and when he urinates the water flows out in several streams.

An examination revealed a contracted meatus urinarius. The circumference of the penis measured three and one-quarter inches which would indicate a urethral calibre of 32 F. A stricture of 14 F. was discerned at three and one-half inches by Otis urethrometer and a filiform stricture in the deep urethra was also discovered. As in the preceding case, the deep stricture was thought to be spasmodic, and in accordance with Dr. Otis' advice, who also examined this patient, the meatus was enlarged to 32 F., and with the dilating urethrotome the contraction at three and one-half inches incised to correspond with the normal urethral calibre of 32 F. After the operation a 32 F. sound was passed without obstruction into the bladder, although a filiform bougie was arrested prior to the operation.

These two cases, among a number of others in the experience of surgeons, afford important examples of the fact that deep strictures are sometimes entirely dependent upon contractions in the anterior urethra and indicate the expediency of first removing the anterior obstructions before resorting to the more serious operation of external urethrotomy.

I have thought that a deep stricture, when spasmodic, imparted a peculiar, elastic resistance to the expert touch when an instrument was

carefully pressed against it, which would tend to characterize the nature of such strictures, but, after all, the surest way of corroborating the diagnosis would be an operative procedure, respecting the anterior contractions, when any exist, and afterwards carefully attempting to pass a full-sized sound. Unless the stricture tissue has been thoroughly divided, the spasm will not be wholly relieved, therefore due caution, to render the operation successful as to results, is advised by attention to the importance of a complete division of the anterior contractions.

One of the above patients (Case II.) had two severe hemorrhages following the operation—one the second day and the other the third day after, but they were readily controlled by the introduction and retention of an endoscopic urethral tube aided by pressure upon the perineal portion of the urethra. The urethral tube was worn for three days without causing any irritation worthy of notice.

It is said that an important diagnostic feature of spasmodic stricture would be the suddenness of its appearance or the possibility of passing urine at some time previous to the attack during the previous twenty-four or thirty-six hours. I cannot agree with these views entirely, for I have seen patients suffering from organic strictures with the same experiences above noted. It may be, however, as stated by Rynd, that "when there is complete retention of urine, and the patient applies, writhing and straining with painful and continued efforts to discharge the contents of the bladder and not a drop appears, the presumption is that he is suffering at present from spasm, no matter what his other troubles may be." In other words, spasm is almost always an element present, or likely to be present, when there is a contracted meatus or a stricture of any calibre along the pendulous urethra. Sometimes spasm is relieved by a warm sitz-bath, followed by a full dose of opium. The patient may be etherized and an attempt be made to pass a catheter if the symptoms are urgent. Should instrumentation be determined upon, I would advise the injection of a four-per-cent solution of cocaine before passing the catheter, as the pressure of an instrument in the urethra may irritate the mucous membrane and aggravate the spasmodic condition to such a degree as to baffle the most skilful operator in its introduction. The sedative effect of cocaine in such emergencies is very positive, whether the spasm be due to irritation reflected by anterior pathological conditions or is purely idiopathic.

I have seen the good effects of its use in both conditions, when attempting to use the catheter or pass sounds for diagnostic purposes. The use of this solution, however, with the ordinary relief which the patient may experience from this treatment can be only palliative and of temporary duration, when an organic stricture complicates the condition of spasm. The only means of permanent relief must be the removal of the

organic lesions, which should be done without hesitation when all other means of relief are without avail, and before the extreme measure of puncturing the bladder is resorted to.

941 MADISON AVENUE.

---

### THE VALUE OF LANOLIN.<sup>1</sup>

BY

GEORGE HENRY FOX, A.M., M.D.

LANOLIN is a fatty substance extracted from the wool of sheep, and recently brought to the notice of the profession in Germany by Liebreich, of Berlin. In an interesting paper, he has discussed the chemical composition of the substance, and pointed out its theoretical virtues. Lassar has followed with a paper in which he reports cases of skin disease, in which he claims that lanolin, as a basis of ointments, has proved itself to be of practical value. A large supply has now reached our market, and we are already beginning to hear from those whose motto would seem to be, *De novis nil nisi bonum*.

According to Liebreich, lanolin is a peculiar substance in which the fatty acids are found in combination with cholesterin, instead of glycerin, as is the case with the fats and oils in ordinary use. It is to be found in the hair or wool, the horns and the hoofs of certain animals, and in the feathers of birds. It appears to be the natural fat of the keratinic tissues. As it is now found in the market, it contains about twenty-five per cent of water, after evaporation of which it becomes stiffer and darker. It is soluble in equal parts of ether, and in two parts of chloroform. It emulsifies with alkalies, mixes readily with lard, oil, or vaseline, and serves as a good basis for ointments, inasmuch as powders rubbed up with it become quickly and finely subdivided. It is strictly neutral in reaction, and is not liable to become rancid.

That it is absorbed by the skin more readily than either lard or vaseline has been claimed for it, and is shown to be a fact by the following experiment, which was made at the Skin and Cancer Hospital under the supervision of the House Physician, Dr. H. W. Blanc.

Upon the anterior surface of the forearms of a young girl, spaces were marked off, four by six inches in extent. Upon the space marked on the right forearm, fifteen grains of lard were rubbed for fifteen minutes. The left forearm was treated with lanolin in the same manner. The lard was softened more quickly by the heat of the skin, and was

<sup>1</sup> Read at the New York Academy of Medicine, Section on Therapeutics, April 21, 1886.

spread much more readily over the surface. With as nearly an equal amount of pressure as it was possible to give, the lanolin was found to redden the skin more readily than the lard. At the expiration of the fifteen minutes, the greasy matter remaining upon each forearm was carefully collected by means of a spatula, and weighed, with the following result:

Weight of lanolin used.....	15 grains.
“ “ “ removed from skin.....	5 “
“ “ “ absorbed.....	10 “
Weight of lard used.....	15 grains.
“ “ “ removed from skin.....	10 “
“ “ “ absorbed.....	5 “

We see, therefore, that while two-thirds of the lanolin disappeared during the rubbing, only one-third of the lard was lost.

To test the comparative rapidity of absorption of lard and vaseline, similar spaces were marked off upon the back of a young man upon either side of the spine and beneath the scapulæ. Fifteen grains of each were rubbed in for fifteen minutes, and the amount scraped off was weighed as before, and with the following result:

Weight of lard used.....	15 grains.
“ “ “ removed from skin.....	8 $\frac{1}{4}$ “
“ “ “ absorbed.....	6 $\frac{3}{4}$ “
Weight of vaseline used.....	15 grains.
“ “ “ removed from skin.....	9 $\frac{1}{2}$ “
“ “ “ absorbed.....	5 $\frac{1}{2}$ “

We note in this experiment that the lard was more readily absorbed than the vaseline, although the difference was not as marked as in the case in which the lard and lanolin were tested.

As a proof of the rapid absorption of drugs by means of lanolin frictions, Liebreich states that a solution of bichloride of mercury in lanolin, of a strength of 1 : 1000, will produce a metallic taste in the mouth, after being rubbed into the skin. I have rubbed repeatedly upon my own skin, as well as upon others, a lanolin ointment of ten times this strength, and failed to get any gustatory proof of its absorption. In some subjects of my experimentation, however, the peculiar metallic taste in the mouth has been noted, but it is possible that a similar effect might have followed the use of lard or even vaseline. As an improvement in our present method of endermic medication, particularly in the



inunction cure of syphilis, lanolin may prove to be of great value, but time will be required to settle this point.

Without discussing further the theoretical use of lanolin, let us consider the question as to its practical value when tested in the treatment of skin diseases. Since the first importation of lanolin from Germany to this city by F. Bague & Co., I have been using it in nearly all cases in which I have had occasion to prescribe an ointment, and I must confess that I have failed to see any remarkably beneficial effects from its use. On the contrary, it has proved objectionable in some instances on account of its color and consistence, and in certain cases of acute inflammatory disease of the skin it has not been found to be as bland as I had been led to expect. When I have used a lanolin ointment upon one side of the body, and a lard or vaseline ointment upon the opposite side, the patient has usually expressed a preference for the latter, and in no case has the rapid absorption of the former been so marked as to attract notice.

In conclusion, my views respecting lanolin may be summed up in the following statements:

1. Lanolin is more readily absorbed by the skin than any other fatty substance.
2. As a basis for ointments, it is useful when an effect upon the deeper skin or upon the whole system is desired.
3. On account of its firm consistency, it is advisable to mix with it a certain amount of lard, especially in cold weather.
4. When applied to a highly inflamed skin, lanolin may not prove as bland as *fresh* lard or *pure* vaseline.
5. Considering its recent introduction, its questionable superiority, and its present cost, it cannot be recommended as yet as the best basis for all ointments.

---

## DERMATOSES OF THE EYE.

BY

CHAS. W. ALLEN, M.D.,

Surgeon to Charity Hospital.

THAT skin diseases should extend at times to the eyelids from adjacent parts is quite natural. It is also easy of comprehension that an eruption of the general cutaneous surface should appear as well on the external or skin surface of the lids, but that eruptions, which we consider as belonging to the skin proper, should occur upon the globe of the eye would seem to require an explanation. A lupus of the eye-

lid may extend to the conjunctivæ, and subsequently attack the cornea; but, as a rule, the successive steps in the process may be watched. So, too, an epithelioma, which first appears as a harmless-looking tumor of the lid, may destroy tissue after tissue until lid, muscle, globe, all are gone, and a hideous cavity alone remains.

When, however, vesicles (as in herpes zoster) or pustules (as in variola) or tumors containing skin elements make their appearance upon the eyeball, we must look deeper than the surface for an exciting cause.

It has appeared to me that those diseases of the eye and its appendages in which occur lesions usually found upon the cutaneous surface, and those skin diseases having an especial predilection for the region of the eye might properly be termed *dermatoses of the eye*, and I have collected under this heading a few recent observations.

#### DERMOÏDE OR HAIRY NÆVUS OF THE CONJUNCTIVA.

Dr. Ficano (*Annali di Ottalmologia*, XIII., fasc. VI.) has recently had under his observation a young girl who presented herself with several hairs growing from the surface of the left globe. They had been first noticed three months before. Contrary to the statements generally made in works on the eye, the tumor was not at the free border of the cornea, but almost a centimetre distant from it, and the hairs were not downy, but quite long and large.

The site of the tumor was at the upper and outer part of the globe, where quite a large area of hypertrophy of the conjunctiva was noticeable.

Twelve hairs were counted growing from the surface of the tumor. They were the color of the girl's hair, but somewhat finer. All the members of the family had abundant hairy nævi on various regions of the body.

Dermoïdes or dermoid tumors of the eye are comparatively rare, as a reference to the reports of eye infirmaries has convinced me. Single and collected cases are, however, to be found scattered through ophthalmological literature, and Graefe, Arlt, von Wecker, and many others have contributed to a knowledge of the subject.

These dermoid tumors are of a yellowish-gray color usually, varying in size from a lentil to that of an olive, situated upon the globe, as a rule, at the sclero-corneal limbus. At about the time of puberty, they become covered with hairs, which may attain a considerable growth. They are not likely to be mistaken for other growths, such as lipoma, sarcoma, or cystic tumor of the conjunctiva, the latter being translucent and having a more rounded form. When excised and examined microscopically, they are found to contain all or many of the elements of the skin. In addition to the hairs and hair-follicles, papillæ, epidermis, sebaceous and sweat glands have been noted.

Various theories have been put forward to account for this exceedingly interesting deformity, but as yet no one, I believe, has been generally accepted. As early as 1838, Prof. Ryba claimed that they were caused by an arrest of development in the eyelids during embryonic life, the ectoderm not being transformed into the conjunctiva until entirely covered by the lids; the arrest of development preventing this transformation at a point resulting in the formation of the dermoid tumor.

#### PATHOGENY OF DERMOÏDES OF THE EYE.

Tillaux gives, in the *Union Médicale*, July 30, 1885, a very plausible explanation of the existence of dermoïdes of the eye, based on a study of embryogeny.

In the very commencement of embryonic life, at about the fourth week, the tegument which passes in front of the primitive ocular vesicle thickens at the point where the cornea afterward appears. This thickened portion becomes depressed in the centre or umbilicated. Soon a pouch is seen to form, which communicates by a very narrow opening with the cutaneous surface; the protuberant part of this pouch passes backward into the primitive ocular vesicle, which is depressed at this level. The epidermic layer thus invaginated produces the lens, while the dermic layer forms the capsulo-pupillary membrane or capsule of the lens. Now, at a given moment, there exists between the lens and the surface of the eye a cutaneous pedicle which soon ruptures and disappears. Now let us suppose that a portion of this pedicle persists at the time of formation of the cornea and sclerotic, can we not easily understand the subsequent apparition of a tumor having all the characteristics of the skin? Based on this embryonic study, the author believes that dermoïdes are formed from the remnant of the embryonic cutaneous layer which persists after the formation of the lens and the vitreous, and becomes imprisoned in the thickness of the external membrane of the eye.

#### ANOTHER THEORY.

Two years ago, Van Huise published an article on the complication of these dermoid tumors, in which he explains their formation in a different way.

He attributes them to the amnion becoming adherent to the globe of the eye during foetal life.

Coloboma of the lids, fissures and wrinkles of the skin are frequently found co-existing with the disease. All of these Van Huise attributes to the same cause, and believes that the dermoïdes cause the coloboma by becoming interposed between the parts which go to form the eyelids. Dr. Larbouret (*Thèse de Paris*, 1885) holds much the same view, believing that amniotic adhesions prevent the complete development of the lids, and give rise to invaginations of the primitive palpebral layer upon

the globe. Dr. Pollak records a case in the *American Journal of Ophthalmology*, December, 1885, and refers to one recorded by Dr. Taliaferro in the *American Journal of Medical Sciences*, 1841, in which he had successfully excised a congenital dermoid tumor from each eye of a fifteen-year-old girl.

Prof. Masse, of Bordeaux, has just published a work on cysts, pearly tumors, and dermoid tumors of the iris, in which he states his belief that the dermoides originate by ectaneous inclusion occurring in some way as the result of a disturbance of development, and that they may remain inert until some traumatism occurs to give an impulse to the proliferation.

#### PEMPHIGUS OF THE CONJUNCTIVA.

Under this title, Dr. Baeumler has published several cases (*Klinische Monatsblätter für Augenheilkunde*, August, 1885) in which a parenchymatous xerophthalmia had developed with its complications of ectropion, cicatricial degeneration and deformity of the lids, and infiltration and ulceration of the cornea. The eruptions of pemphigus had been observed during the disease on the body, and also upon the eyelids.

Various authors have mentioned such complications (Alibert, Cooper, Hardy, Wecker). Dr. Boucher (*Recueil d'Ophthalm.*, October, 1885) objects to the name "pemphigus of the conjunctiva," and says that the disease is the last step in an inflammatory process, resulting, as Weber, Cohn, and others have shown, from widely diverse causes, among which are ectaneous affections which have extended to the eye.

Mr. Lang read a paper on this same subject at the London Ophthalmological Society, Nov. 12, 1885. He described two cases, both occurring in women.

In one case blisters had appeared on the backs of the hands and front of the body in 1876, since which time she had never been free from the eruption. A vigorous shake of the hand would produce a blister. The palms and fingers were smooth, thickened, and contracted, and the toes were in the same condition. At the same time that these changes in the skin began, the eyelashes turned in and the whites of the eyes became red.

In the other case, the right palpebral fissure was much shorter and narrower than normal, both lids being completely adherent to the globe. The conjunctiva was replaced by a dry, black, opaque membrane.

#### ZONA OPHTHALMICA.

The monograph of Hybord (*Thèse de Paris*, 1872) on zona has become classic, although the disease had been previously described by Hutchinson, Bowman, Arlt and others.

Two forms of the disease are encountered: one benign, the other severe.



The first is never accompanied by affections of the eye; the second does produce alterations of this organ.

According to Besnier (*Journal de Méd. et de Chirurg.*), the difference in the two forms of the disease depends upon the severity of the lesion of the Gasserian ganglion, which is proper to zona, and upon the localization of the disease on the various branches of the trigeminus.

So long as the ethmoidal nasal branches are not involved, we have to deal with the benign form. The disease becomes severe if the nasal cavity and the eye are attacked.

To be able to predict that the cornea will be involved, and to prevent it, frequent examination should be made of the sensibility of the cornea, and of the appearance of the eye, in every case of zona of the face.

An œdematous redness of the conjunctiva and the appearance of small vesicles on the cornea or sclerotic is usually noticed in the severe form. The iris may be altered, small ulcerations may replace the vesicles, and in rare cases there may be facial paralysis by propagation.

The treatment of zona is unsatisfactory, being mainly directed toward the symptoms. External medication consists in the application of hot emollient fomentations, inunction of glycerole of starch and extract of belladonna, wet compresses to the eye, and instillations of atropine sufficient to keep the pupil dilated.

The pain may persist long after the eruption has disappeared, especially in elderly persons.

#### TUMORS OF THE EYELIDS—MELANOTIC SARCOMA.

A case of this rare disease was observed at the clinic of Dr. Bruno, in Turin (*Gaz. delle Cliniche*, 1884, No. 35). The subject was a woman of sixty-six years, who had never had any serious disease. A small, black, pediculated tumor first appeared at the middle of the ciliary border of the right upper lid. This was removed by a ligature, but a month and a half later another formed, and within fifteen months reached the size of a hazelnut. It was now completely excised. Microscopical examination showed an infiltration of young connective-tissue cells in the skin and orbicular muscle. The tumor itself was made up of small and large round cells and fusiform cells, the latter being in greatest abundance. The pigment was disposed in round heaps, and also in granulations, occupying in part the interior of the cells.

The stroma was formed of connective tissue with small spaces. The nucleus, as is often the case in pigmentary sarcoma, was free from pigment.

Dr. Gallenga refers to the extreme rarity of these tumors, having found two publications only on the subject, one being by Gibson, the other by Horner.

(To be continued.)

PEMPHIGUS FOLLOWED BY ALBUMINURIA.<sup>1</sup>

BY

R. H. SABIN, M.D.,

West Troy, N. Y.

THE subject of this case was the mother of five children, four of whom are living and in good health. She was of Scotch descent. Her parents are both living, father at the age 83 years, and mother 81, and in good health. She had a clear, fair, white skin, was about five feet four inches tall, and in her usual health weighed 110 pounds.

In the year 1874, January 1, she gave birth to her third child, had an easy labor, and got along well till, the fifth day, she broke out on her hands and arms with watery blebs, or an eruption described under the name of pemphigus; another name given it is pompholyx. These blebs or bullæ were oval-shaped bladders varying in size from a split pea to a large walnut. Each bulla contained a semi-transparent fluid which soon became opaque, and after a few days dried up, leaving a small scab, or giving rise to an excoriated surface, but no scab. One crop followed another on the same surface, and sometimes spread over the whole leg or arm, and sometimes on the body.

After about four weeks of good tonic treatment she recovered, and remained in good health till after her next confinement, which occurred April 6, 1876, two years and three months from the previous confinement.

On the third day after, she again broke out, much more severely than the previous time; now it extended all over the hands, arms, feet, and legs, and also on the body. On the hands, feet, and legs, up to the knee, they were very thick, running into each other, forming a complete layer of watery blebs; so thick, that not a spot of sound skin could be seen between. They were very painful, the burning, smarting pain depriving her of sleep night and day.

After a tonic course of treatment of about three months, they went away, leaving her again in her accustomed health, which continued good till she again found herself *enceinte*. When about three months gone she broke out again, the eruption continued till about two months previous to her confinement, when it went away till after confinement, which occurred on the third day of November, 1879. She gave birth to a plump, healthy boy, with an easy labor; had got through when I arrived; got

<sup>1</sup> Read before the Union Medical Society in Troy, N. Y., April 6, 1886.

along well till, the third day, she broke out again, the eruption yielded to a tonic treatment in a few days, leaving her as well as usual.

The following pills were used in this case, which seemed to do more good than anything else.

R Quinine..... gr. i.  
 Quevenne's Iron..... gr. i.  
 Arsenious Acid..... gr.  $\frac{1}{32}$ .

Dose. One three times a day.

May 10, 1885, I was again called to see the same patient, when she complained of being so weak and languid that she could hardly keep about. Since the previous visit narrated above she has lost her husband, now about two years ago, with consumption, and for the last two years she has had the care of her aged parents, as well as her own family.

I now find her with feet and ankles swollen, and evidently dropsical. An examination of her urine showed a large proportion of albumin; she looked care-worn, and weary.

I put her on a tonic and diuretic course, with as much Poland water as she could drink; but the dropsy continued, and she gradually lost her strength till she died, October 1, 1885.

Her mental faculties, also her eyesight, continued good till the last.

Post-mortem, twenty-four hours after death. Rigor mortis well marked. Body well nourished, skin very white. Stomach and liver, as well as the other organs, except the kidneys, were normal and seemed to be healthy. The kidneys were of the white variety, though not much enlarged, soft and smooth surface when cut across. Its investing membrane easily stripped off. The cortical substance had lost its red tint, and presents a pale appearance.

Watson says: The coarse anatomical characters of the kidneys in the two more chronic forms of Bright's disease are in striking contrast with each other. They differ remarkably in size and color, and are spoken of as the large white and small red kidney. The average weight of the adult human kidney is between four and five ounces. In Bright's disease, some have been met with weighing twelve ounces, others weighing scarcely two. The large white kidney is generally of soft consistence, and has a smooth surface, which is apt to become indented by linear depressions, and so to assume in its enlargement a lobular shape. Its proper investing membrane is easily stripped off.

The small contracted kidney, on the contrary, is hard and red; its surface is rough, as if strewed with prominent grains, and has sometimes a scarrred appearance, and its outer membrane comes off with difficulty.

The cortical substance being the main seat of the morbid changes, the alteration of color is the most conspicuous in the cut surface of the

large kidney, which has lost its red tint and its orderly aspect, and presents a pale, nearly homogeneous appearance; not unlike, in some cases, the section of a parsnip. Its natural striæ are confused or obliterated. The incised surface gives one the notion of some deposit whereby the original texture of the part is obscured.

The blood-vessels, many or most of them, seem to have been emptied by compression, or to be blocked up by yellowish solid matters; while the healthier pink pyramidal masses belonging to the medullary portion of the kidney appear to be displaced or pushed aside, or encroached upon by the same yellowish matter, which sometimes interposes itself between and opens out their radiating tubules. Together with these changes of appearance, I have several times found the veins that emerge from the kidney firmly plugged up by coagula of blood.

---

### LEUCODERMA OR VITILIGO.

BY

J. A. WESSINGER, M.D.,

Howell, Mich.

THE subject of this article is Mrs. E., æt. 60; married. Her parents were both pure-blooded colored people. Mrs. E.'s grandfather was a native of Guiana; the maternal grandmother was a slave in the days of Washington. The ancestors of the patient, as well as most of her relatives, are very dark. She was married when quite young, and from this marriage have followed nine well-developed colored children. The disease in question first made its appearance in 1856 in the form of a white spot on the side of the right leg, which slowly spread, and in time was joined by similar spots on her breast and over the main parts of her body. About fifteen years ago, there came little rings of white about her finger nails, which gradually extended upwards, covering her hands and arms. In the mean time, the white upon her body crept up the back of her neck and over her scalp.

About a year ago, the color upon portions of her face began to give way, and two or three large macular areas are now to be seen. According to authorities on the subject, the disease, once developed, may continue for an indefinite period, or, after a time, come to a standstill, and remain in that condition for many years. Occasionally spontaneous recovery takes place, that is, the skin may recover its normal coloration. The disease affects the Caucasian as well as the negro, and probably the races of intermediate tint. It has never been met in childhood in the



white race, but it has been seen from early adult life to old age. It may be confounded with but a few others, such as partial albinism and certain phases of macular leprosy. In an analysis of eleven thousand cases of skin disease, Dr. McCall Anderson met with only four cases of vitiligo. The treatment of the disease in question is of necessity very unsatisfactory, although in the above case the use of faradism seemed for a time to retard its progress. In a paper read by Dr. R. Harvey Reed, of Mansfield, O., before the Ohio State Medical Society, on the subject of leucoderma, the following conclusions were formulated:

1. The disease is not confined to sex, and usually begins in adult life.
2. This affection may be confounded with morphœa, chloasma, tinea versicolor, lentigo, partial albinism, and certain phases of macular leprosy. The disease is quite easily differentiated from these maladies.
3. This disease is probably a nervous affection, and traceable to the great sympathetic system which produces an altered blood supply, and hence the perverted pigmentation of the derma.
4. Treatment is very unsatisfactory, although an apparent benefit may be derived from the use of electricity.

Dr. Duhring defines this cutaneous affection as an acquired disease, consisting of one or more sharply defined, rounded, irregularly shaped, variously sized and distributed, smooth, whitish spots, whose borders usually show an increase in the normal amount of pigment.

Prof. Piffard gives the following definition and description of the disease in question:

“Vitiligo is an affection characterized by a localized disappearance of the cutaneous pigment. It becomes noticeable by the development of one or more small pigmentless spots, the color of which varies from a dead-white to a faint rosy hue, the particular tint depending on the activity of the circulation in the affected part. The hair, if there be any on the spot, loses its color, and becomes white. Surrounding these pale patches, there is frequently a border characterized by increased pigmentary deposit, which gradually shades off into the hue of the normal surrounding skin. The appearance of one spot is usually followed by the development of others. The spots usually, for a time, increase in size, and unite with neighboring ones after forming an irregular patch of considerable extent. A considerable, and even the major part, of the surface may be thus invaded. With the exception of the loss of color, the affected portions do not present any other anomaly, but appear to preserve their various functions unaltered. The parts most frequently affected are, in my experience, the hands, face, neck, and genitals.”

## Society Transactions.

### NEW YORK DERMATOLOGICAL SOCIETY.

163D REGULAR MEETING, APRIL 27, 1886.

DR. W. T. ALEXANDER, *President*.

DR. FOX showed a case of

#### MACULAR LEPROSY.

The patient, a Cuban, has had the present eruption for the past twelve years. The lesion exists chiefly on the trunk in the form of brownish pigmented spots, in which the tactile sensibility is lessened. The patient naturally has a rather large amount of hair scattered over the body, but where the patches are there is an entire absence of hair. There is mottling of both arms and considerable scaling of the elbows. The face and other portions of the body present a bronzed appearance, and there is a commencing leonine aspect of the face. There is also considerable adenoma present.

DR. SHERWELL said that the case appeared to him to be one of macular leprosy, but he would prefer suspending judgment until he could examine the patient more carefully by day-light.

DR. ALLEN had never seen a simple case of macular leprosy, but had observed macular lesions in connection with other forms of the disease.

DR. FOX said that it was impossible to make a diagnosis except by day-light, and while he was not absolutely positive as to the nature of the disease, he did not see what else it could be. He made his diagnosis from the fact that the disease was endemic where the patient lived, the brownish appearance of the macules, their annular form with a tendency to fade in the centre, the marked anæsthesia of the spots, as well as the swelling above the eyes, and the bronzed appearance of the skin.

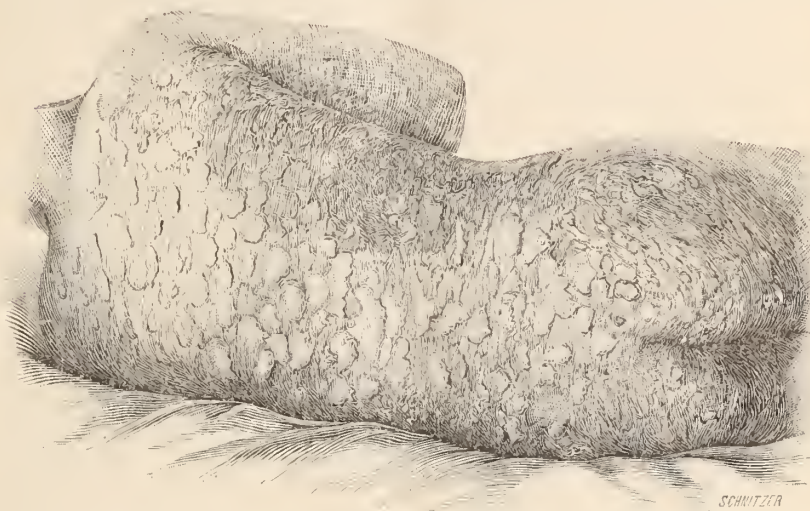
DR. MORROW presented a case of

#### PITYRIASIS RUBRA, WITH VESICULAR LESIONS.

The patient, æt. 37, a compositor by occupation, had been admitted to the dermatological ward in Charity Hospital, April 27. The case was presented not only on account of the comparative rarity of this affection, but principally on account of the presence of certain eruptive elements not usually seen in pityriasis rubra.

The patient was a hard drinker, had never had any venereal trouble; his father was scrofulous; all the other members of his family healthy. He had various attacks of skin trouble for the past twelve years, but had been comparatively free from any eruption for a period of nearly three years past. Three months ago, the present eruption began as small, red patches, somewhat scaly, which gradually grew larger and ran together, until now the entire surface of the body is occupied by the eruption, which is everywhere confluent, except upon the dorsal surfaces of hands and wrists, and below the knees, where it exists in the form of rounded reddish patches. Twice before, according to the patient's statement, the eruption had been generalized, but the scaling was not so extensive as at present. The characteristic features of pityriasis rubra are admirably shown in this case, the abundant exfoliation of dry, papery scales, which are

easily separated from their attachment, and flake off in very thin lamellæ, showing beneath a red, dry, non-infiltrated shining skin. The peculiar interest of the case, however, consists in the presence of innumerable pin-head-sized vesicles, or vesico-pustules, with which the palms and soles are thickly studded, showing beneath the thickened epidermis of these regions as opaque or yellowish points. In the central portions of the palms they have become confluent, completely detaching the epidermis from its subjacent connections. There is also seen a circle of closely set, minute pustules completely surrounding the reddish patches upon



the dorsal surfaces of the hands, wrists, and the lower extremities. These vesicles are developed in the extreme peripheral margin of the patches, and are, according to my observation, altogether unique.

DR. FOX said that he had never seen a case of pityriasis rubra where vesico-pustules were present, or where there was the condition seen on the legs. The upper part of the body certainly presented the characteristic appearances of pityriasis rubra. It would be well to consider whether two distinct diseases might not be present.

DR. ALLEN would make the diagnosis of pityriasis rubra, but believed that some other condition was associated with it.

DR. SHERWELL believed that it was a pityriasis rubra, or pemphigus foliaceus, and if it were the former, it was an uncommon form.

DR. MORROW said that he had shown the case because of the vesico-pustular element present, which all would recognize as entirely foreign to the classical features of pityriasis rubra. When he first saw the patient's hands, before looking at the remainder of the body, he thought it might possibly be a pemphigus foliaceus, but on close questioning he found that there had been no bullæ, nor had there been any moisture at any stage of the disease. He believed that the condition on the limbs did not exclude the diagnosis of pityriasis rubra. In previous attacks, the lesion commenced in small red spots, running together and forming large patches. He (Dr. Morrow) said that many authorities recognized a certain relationship existing between pityriasis rubra and pemphigus foliaceus; it was not surprising, therefore, that they might have an exudative element in common. He had never seen a more typical case of pityriasis rubra as far as the body was concerned, there being no thickening of the skin and abundant scaling, the scales being made up of thin lamellæ.

DR. FOX asked Dr. Morrow if he had ever seen or read of a vesicular eruption in connection with pityriasis rubra.

DR. MORROW said that he could not recall a similar case in his own experience, but he believed that an exudative element might be present in pityriasis rubra, and yet be so slight as to escape observation. He recognized the fact that any chronic skin disease might be modified in its typical features, and, also, that accidental eruptive elements might be superadded, either from local or constitutional causes. In this case, for example, the added phenomena may have been determined by chronic alcoholism.

DR. SHERWELL had had at least half a dozen cases of pityriasis rubra, but never saw one where the scales were so tremendously large. He often had examined the urine, but had not found albumin: there was an abundance of urates.

DR. TAYLOR spoke of a case of pityriasis rubra, which he saw with Dr. Zinsser, in whom the urine was examined, and sugar found. He had examined the urine in other cases of pityriasis rubra, and found sugar which disappeared after the involution of the disease. He asked Dr. Sherwell if he had ever examined the urine for sugar in such cases.

DR. SHERWELL said that he had examined only one case, and in that one no sugar was found.

DR. MORROW thought that it would be interesting from a pathogenetic point of view to inquire whether there was any relationship between this chronic form of disease and the acute dermatitis exfoliativa produced by the ingestion of certain drugs. Many of the drug exanthems are often followed by more or less extensive desquamation. He had seen a case where the epidermis had exfoliated in large flakes from the surface, and had been stripped from the fingers like a glove.

DR. MORROW afterward showed a case of

#### ARSENICAL ERUPTION.

The patient, a boy, aged 11, had been sent to him a few days ago by Dr. Gottheil, of the New York Polyclinic, for an opinion as to whether the eruption was an arsenical dermatitis. In the latter part of February the child was suffering with chorea, and was put upon arsenical treatment, commencing with five drops of Fowler's solution, and increasing to sixteen drops three times a day; it was decreased in quantity, because it caused conjunctival and gastric disturbances, with puffiness of eyelids and swelling of the ankles and feet. Some time in March an eruption developed on the body and extremities, which, according to the mother's statement, always became intensified when the doses of the arsenic were increased, and began to disappear when the arsenic was temporarily discontinued. The lesion was erythemato-papular, the spots running together and forming patches. It presented many of the appearances of a rubeolous eruption, and was extremely itchy. The skin was rough, and in some places desquamating; there was a grayish-brown, almost black, discoloration of the surface, especially marked over the abdomen and inner surface of the thighs. The dorsal surfaces of hands were occupied by a coating of a greenish color, cracked and fissured, resembling ichthyosis. The tongue was pale and flabby. The discoloration was evidently pigmentary, and could not be removed by friction with soap.

DR. KEYES saw no reason why it was not an arsenical eruption. In one case of rebellious psoriasis to whom he gave large doses of arsenic, an extensive papular eruption made its appearance on the neck and body, accompanied by intense pruritus; the eyes were swollen, and the tongue red. Exfoliation of the skin followed, disappearing when the administration of the arsenic was stopped.

DR. GOTTHEIL, by invitation, said that when he first saw the case, three weeks ago, the eruption was more decided, and the flexures of the joints were markedly inflamed. The backs of the hands were covered with an eruption of large papules, which gave place to the peculiar scaly coating now present. He asked if the pigmentation of the surface was due to the administration of arsenic.



DR. MORROW replied that a grayish or dark-brown pigmentation was one of the most characteristic features of the prolonged use of arsenic. Its occurrence was mentioned by many authors. Bazin had compared it to a staining of the skin by nitrate of silver. It was a question whether the discoloration was due to a chemical combination or an abnormal deposition of pigment. The discoloration was generally brownish, and in this case a peculiar feature was that it was greenish upon the hands, and almost black upon the abdomen and thighs.

DR. FOX thought the greenish discoloration was secondary and due to the dirty condition of the skin.

DR. MORROW said that the acute erythemato-papular eruption was the most common form of arsenical dermatitis, although almost every variety of eruptive disorder had been observed to follow the ingestion of the drug.

DR. FOX read a paper on

#### THE VALUE OF ARSENIC IN SKIN DISEASES,

which may be summed up as follows: The very common practice of giving arsenic in nearly every case of skin disease is irrational and harmful.

It is irrational, because in the majority of cases the remedy produces very little, if any, benefit.

It is harmful for the following reasons:

a. In many cases it increases cutaneous congestion, intensifies pruritus, and thereby aggravates the eruption.

b. It is very frequently relied upon to the exclusion of other and better plans of treatment.

The universal employment of arsenic in the treatment of skin diseases is no more a proof of its value than was the former practice of venesection for most diseases a valid argument in favor of that plan of treatment.

The beneficial change which sometimes follows the use of arsenic is frequently due to adjuvant treatment, and erroneously attributed to the administration of this drug.

In spite of the wide-spread belief in the value of arsenic, there has never been published a series of carefully recorded cases in which the sole administration of this drug has produced any notable therapeutic results.

There are some forms of chronic inflammatory skin disease, and possibly some affections of a malignant type, in which the internal use of arsenic will undoubtedly exert a beneficial influence.

In most cases of inflammatory skin disease, regulation of the diet, and such hygienic and medicinal treatment as tends to improve the general health of the patient will do infinitely more good than the routine administration of arsenic.

---

**GANGRENE CAUSED BY IODINE-COLLODION.**—The application of iodine-collodion to a frost-bitten finger in Vienna last year, it will be remembered, led to a loss of the finger and the suicide of the physician from mortification on account of the unfortunate notoriety given the case. Dr. Vogelsang, of Biel, now reports (*Memorabilia, Med.-Chir. Rundschau*) a case in which iodine-collodion painted over a large surface was followed by gangrene of the skin and sloughing. In one case collodion was applied over a gland which had been painted with iodine; the result was a slough and an ugly ulcer.—*Med. Times*, April 3, 1880.

## Correspondence.

---

### THE TREATMENT OF RHUS-POISONING.

CHARLESTON, W. VA., April 26, 1886.

Prince A. Morrow, M.D.

MY DEAR DOCTOR:—Will you please give us in the next number of your JOURNAL OF CUTANEOUS AND VENEREAL DISEASES a reliable remedy or remedies for poison oak or rhus toxicodendron? We have a great many cases here, and especially at this time of year.

I have as yet seen nothing worth mentioning in the books or journals that would do more good than cream or vaseline. If we have a safe, efficient, and reliable remedy, will you please give us the benefit of it?

Yours respectfully and fraternally,

WM. W. TOMPKINS,

*Sec'y of the Medical and Surgical Society of the Kanawha Valley.*

In undertaking the task of giving our correspondent a "reliable remedy" for the treatment of rhus-poisoning, the editor of the JOURNAL finds himself confronted with an embarrassment of riches. Medical literature abounds in recipes which have been from time to time recommended as possessing specific virtues in the treatment of this distressing affection: but, however valuable they may have proven in isolated cases, their claims to infallibility have, unfortunately, not been confirmed when submitted to the test of extended clinical experience. It is well at the outset to recognize the fact that *there is no specific for the cure of dermatitis venenata*. It is to be treated on the same general principles as are indicated in the treatment of other inflammations of the skin directly provoked by external irritating agencies. The inflammation is self-limited, with a tendency to spontaneous recovery, and the principles of rational treatment are to relieve the subjective sensations of burning and itching, to modify the inflammatory action, and to prevent the extension of the eruption.

It is well known that the eruption first develops upon parts brought in direct contact with the leaves of the plant, or exposed to their emanations, as the hands and face. The poisonous principle of the rhus resides in a volatile acid termed *toxico-dendric acid*. It is still a moot point whether the extension of the inflammation to other parts of the body is a systemic effect, consecutive to absorption of the poisonous principle, or whether it is due to a direct inoculation of the parts by the nails, as in scratching. The latter view is, I think, the most probable; certainly, clinical experience conclusively proves the auto-inoculability of the eruption.

With a view of circumscribing the spread of the eruption, the patient should be cautioned against bringing the hands in contact with other parts of the body; especially should he be enjoined against handling the genital parts, as the integument of this region is peculiarly susceptible to the irritant action of the rhus. It is a matter of common observation that the genital parts of the male are much more frequently the seat of the eruption than the corresponding region in the female, and the explanation is found in the direct transfer of the irritating agent by the fingers in handling the parts during the act of micturition, in dressing, etc.

The treatment of the acute stage of the eruption should be essentially soothing

and protective. For this purpose, dusting powders and sedative or mildly astringent lotions should be used.

A lotion which I am in the habit of employing with good results is the following :

℞ Sodii hyposulphitis. .... ʒ i.  
Glycerinæ ..... ʒ ss.  
Aq. .... ad ʒ viij.

M.

Apply with compresses dipped in the solution and frequently renewed. I have also used a strong solution of the sulphite of sodium with marked benefit. Two years ago, I treated several cases by simply painting the affected surfaces, every two or three hours, with sweet spirits of nitre. It seemed to have a very favorable effect in relieving the cutaneous congestion, besides imparting, as one of the patients expressed it, a "cooling sensation" to the surface. In cases where the continuous application of a lotion is impracticable, freely dusting the surface with an absorbent powder is to be recommended. I am in the habit of using Pears' Fuller's Earth, which is perfectly bland and unirritating, or the following combination :

℞ Pulv. Zinci oxidi. .... ʒ ij.  
" Bismuthi subnitrat. .... ʒ i.  
" Amyli ..... ʒ v.

M.

It is important that the affected surface should be kept copiously covered with the powder ; an occasional sprinkling does little good. If there is much burning heat present, a little powdered camphor (ʒ ss. to the ʒ i.) may be added.

When the more acute eruptive features have begun to subside, a mild, soothing ointment should be employed. For this purpose, I know of nothing better or more universally applicable than the ordinary benzoated zinc ointment. Another very excellent dressing in this stage of the disease is the Lassar paste :

℞ Pulv. Zinci ox.,  
" Amyli. .... āā ʒ ij.  
Vasellini ..... ʒ iv.

M.

It is not claimed that the plan of treatment outlined above is in any sense specific. The writer has employed it, modified, of course, to meet indications in particular cases, in a large number of cases, with the effect of relieving distressing symptoms, and materially hastening recovery. The good effects of the same treatment will be found to vary in different patients. There is a great difference in the susceptibility of different individuals to the irritant action of the rhus poison, and the difference in susceptibility is perhaps equally marked in relation to the influence of medication.

Two cases of rhus-poisoning came under my observation last summer, both members of the same family ; in both, the initial features of the eruption were equally severe, both were submitted to the same treatment ; in one case it was promptly effectual, in the other the inflammatory symptoms continued, with scarcely any abatement, for several days.

Should the editor's treatment not fulfil the conditions demanded by our correspondent, he need not be discouraged, especially if he believes that in a multitude of remedies there is safety. It is not possible to here enumerate the entire list of remedies which have been recommended in the treatment of rhus-poison-

ing, for their name is legion. To give only a few which are claimed to possess a remarkable efficacy in subduing the symptoms: lime-water; alum curd; a saturated solution of bicarbonate of sodium; a strong solution of chlorate of potassium; a solution of sulphate of zinc ( $\frac{3}{4}$  ss. to the pint): a solution of carbolic acid (grs. ij.-iv. to the  $\frac{3}{4}$  i.): a weak solution of sulphate of copper; dilute lead-water, etc. Compresses to be wet with these lotions, and applied every hour or two through the day. Dr. White, of Boston, and others, highly praise the efficacy of the ordinary black wash. Dr. Brown, U. S. N., claims that bromine (ten to twenty drops to the ounce of olive-oil or cosmoline) is a specific.

To turn now to the vegetable materia medica: a decoction of white-oak bark; a decoction of the bark or leaves of the elder; an infusion of the sweet fern; the tincture or fluid extract of serpentaria, lobelia, sanguinaria; infusion of the bark of the red sassafras, with sassafras tea, *ad libitum*, internally, have all been highly spoken of. Probably the most efficient of the vegetable remedies is the grindelia robusta, which may be used in the form of the fluid extract, diluted in ten to thirty parts of water.

Dr. Hyde speaks enthusiastically of an ointment made by incorporating a decoction of the inner bark of the American spicebush (*Benzoin odoriferus*) with cold cream. Dr. Edson highly extols the virtues of gelsemium in the treatment of rhus-poisoning (*Medical Record*, vol. xxii., p. 120). His formula is:  $\mathcal{R}$  Acidi carbolic,  $\frac{3}{4}$  ss.; Fl. ext. Gelsemii,  $\frac{3}{4}$  ij.; Glycerini,  $\frac{3}{4}$  ss.; Aq., ad  $\frac{3}{4}$  iv. M. Cloths to be moistened with this lotion, and applied to the affected parts. This, he claims, with the internal administration of the fluid extract of gelsemium every three hours, effectually relieves the burning and itching, and the eruption speedily disappears.

EDITOR OF THE C. AND V. JOURNAL.

## DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

### Purpura.

A PAPER by Dr. Bristowe, entitled "Clinical Remarks on Purpura Urticans, with Cases" (*Medical Times and Gazette*, May 9, p. 599), is of considerable interest. Two cases are narrated, occurring in boys aged 15 and 10 respectively, which bear a close resemblance to each other; in both there was abdominal pain and melæna, with persistent renal hæmaturia; and in both there was, from beginning to end, a recurrent purpuric urticarial eruption, affecting mainly the extremities. There was slight tendency to bleeding from other parts, as shown by spongy gums and epistaxis, and both patients became very weak and ill, although it did not appear that much blood had been lost, and, lastly, ordinary petechiæ, vibices, and ecchymoses, did not occur in either. Dr. Bristowe remarks that this combination of symptoms can hardly have been accidental, and does not accord with what is observed in ordinary purpura; the hæmorrhages, especially, occurred in connection with wheal-like tubercles of short duration. They began with the development of these tubercles, and ceased with their subsidence, the effused or accumulated blood then undergoing gradual removal by absorption. They never presented the deep violet tint and definite margins which usually characterize the petechiæ of purpura. They were always of a more or less vivid red, somewhat spotty in appearance, and, indeed, gave the impression not so much of a limited abundant extravasation, as of either permanent stagnation of blood in dilated capillary vessels, or groups of punctiform extravasations. Both cases got well while under arsenical treatment. A "case of rheumatic purpura" is reported in the same number of this journal (p.



608) by Dr. Sadler, and is of interest, as doubt has been recently thrown by Immerman (in Ziemssen's "Cyclopædia") on the existence of purpura as a phase of rheumatism. In Dr. Sadler's case, though the fever was not very high ( $100^{\circ}$  to  $101^{\circ}$  F.), and though the articular pains followed the rash, every symptom of acute rheumatism was represented; articular swelling, sweating, periosteal nodes, and endocarditis. There was no hæmaturia. A case of "Acute Purpura Hæmorrhagica in a Child" (a little boy, aged 3 years) is reported by Dr. Gibbons (*Medical Times and Gazette*, January 3, p. 2). The case ended fatally, in spite of careful treatment.

### Pemphigus.

"The bullæ of Pemphigus" have been examined with regard to the presence of micro-organisms in their contents (as stated by Gibier) by Dr. G. Thin (*Lancet*, May 30, p. 981). He gave a full trial to the various methods of staining and cultivation which are now employed, and always with an entirely negative result.

### Hyperidrosis.

A very remarkable "Case of Sweating to Death" has been placed on record by Dr. Myrtle (*Medical Press*, February 25, p. 164). An old man, aged 77, was seized with slight rheumatism without fever, from which he obtained complete relief by small doses of salicylate of soda. In about three weeks he began to perspire rather freely, and continued to do so copiously at intervals for about ten days, when the pains left him completely. He was treated now for the sweating only, which continued, by arsenic, cinchona, and sulphuric acid during the day, and quinine and belladonna at bed-time, the body being sponged with solution of common salt containing eau de cologne and vinegar once a day, and the wet underclothing changed as often as practicable. The patient at this time felt quite well except for the sweating, had no fever, no thirst, and passed urine normal in character and quantity. The sweats used to come on quite suddenly, the sweat literally pouring out of every duct, and this would go on for ten minutes or ten hours, but invariably stopped as suddenly as it began; everything on or about him was simply saturated. Ague being suspected, Warburg's tincture was now given in full doses, and the quinine and belladonna continued, but no improvement took place, and later "the sweat became most offensive, giving the same heavy smell as that given off by a horse after a smart gallop on a hot day." The case being considered as due to paresis of terminal branches of nerves supplying the sweat glands, ergotine was tried, two doses of three grains each being given at an interval of eight hours; soon after the second dose toxic results ensued, from which recovery took place under stimulants, hot bottles to the feet, and sinapisms to the chest and nape of the neck, but the sweats were not controlled; in the following twenty-four hours fifteen distinct bursts of perspiration were observed, lasting from a few minutes to a couple of hours, and it was found that during the intervals the skin, although soft and sodden, was not wet, but during the attacks it was no sooner wiped dry than the sweat was again seen standing upon it. The next remedy tried was atropia, gr.  $\frac{1}{30}$  being given morning and evening, the surface of the body being also dusted with salicylic acid and starch. In an hour after the administration of the atropia, severe symptoms of poisoning were developed, and the patient nearly died; he rallied, however, and then the sweating went on just the same. It was then decided that arsenic should be resumed, and accordingly five minims of Fowler's solution were given

twice a day, with Warburg's tincture, and in forty-eight hours the perspirations ceased and kept away for twenty-four hours; they then recurred slightly, but for a week there was so little sweating that recovery was anticipated, when they suddenly recurred, worse than ever. All this time there was no constitutional disturbance, the pulse was 72, and the temperature normal. The arsenic had to be stopped soon afterwards, owing to the development of dryness of the mouth and throat, with inflammation of the conjunctiva, and eucalyptus was now substituted, morphia being given at bed-time. The sweating, however, continued with unabated severity until his death, which took place from exhaustion in four months from the first onset of his illness.

### Raynaud's Disease.

Two cases of this singular disorder were communicated to the Clinical Society on May 22 by Dr. Colcott Fox. 1. A nervous woman, aged 41, had suffered at least ten years; at first all her fingers continually went "like white wax;" this condition of local syncope gradually passed into local asphyxia, and the feet became involved. The fingers gradually became chronically cyanosed, this condition being intensified by frequent severe attacks, often leading to ulceration. The nutrition of the phalanges had suffered greatly, so that her hands were crippled, the fingers fusiform, livid, shiny, and withered, the nails variously distorted, and the end-phalanges much atrophied and almost immovable. The nose and ears were somewhat affected on exposure. Cold and nerve-shocks were ready exciting causes.—2. A man, aged 51, with diabetes. He had suffered for several years from dead fingers, but there was no deformity. Symmetrical gangrenous patches appeared on the skin, and there was marked local asphyxia of the big toes. There was no hæmoglobinuria in either case. Mr. Cripps (who thought the second case was one of diabetic gangrene) thought that these cases were not far removed from frost-bite and senile gangrene, between which Raynaud's disease seemed to hold an intermediate place. Many of these patients had cold extremities, which at length became gangrenous when the weather was very cold. Dr. Barlow said that Raynaud had recommended the use of the constant current for these cases. A patient of his own, a man aged 42, for two years had suffered so severely in the feet that he could not walk, and was not entirely well even in the summer. Last autumn the constant current was applied, one pole to the spine and one to the extremities; but this was useless. It was then tried with both poles to the extremities, and kept up for about twenty minutes a day to each extremity for eight months, with benefit. The feet soon had a warm glow, and the result apparently had been permanent. The man now shampooed his feet every day, and could do his work. In two other cases, in children, which he had already communicated to the Society, the attacks only came on when the cold weather appeared. The paroxysms usually lasted about two hours, and came on at nine and five o'clock every day. The feet were quite cold, black, and intensely painful. In one attack, ten minutes after its commencement, a bath of salt and water was used; one pole of a Leclanché battery was applied to the limb in the water, the other pole some inches above the ankle, and the benefit was considerable. In another patient he had also tried galvanism, and the benefit was great. He had tried nitrite of amyl; the face flushed, but it had no influence on the local condition of the extremities. At the same meeting of the Society, Dr. A. T. Myers showed a case of Raynaud's disease affecting the ears, with paroxysmal hæmoglobinuria. The patient was a boy aged 12, and both ears showed

scars of symmetrical gangrene, from which he suffered for about two years. Since then there had been cyanosis, tenderness and aching of the ears on any slight exposure to cold, but no actual gangrene. Together with the first appearance of gangrene, attacks of paroxysmal hæmoglobinuria came on, and had continued ever since. Neither syphilis nor malaria could be traced in the history of the case. This patient was for some time under the care of the present writer, together with another, a man aged 34, who was affected in a precisely similar manner, with the exception that the gangrenous or ulcerative process was active in his case; it was also quite limited to the ears, which were originally thought by Raynaud to be exempt from actual gangrene, although they were often attacked with cyanosis occurring paroxysmally. This patient had suffered from ague eight years before the first appearance of hæmoglobinuria, which preceded the local asphyxia by about a year.

JOHN CAVAFY.

LONDON.

---

## Selections.

---

### URETHRAL INJECTIONS IN GONORRHOEA.

THREE principal points are to be considered in the study of urethral injections: their composition; the time when they should be employed; the mode of employing them.

#### THE COMPOSITION OF INJECTIONS.

The general principle may be laid down that every urethral injection should be antiseptic or at least aseptic, that is, it should not contain germs. The importance of urinary antiseptics is recognized by every careful surgeon, and every one who performs a lithotomy, a dilatation, or even a simple catheterism, pays particular attention to the cleanliness of his instruments. But in the case of injections it is quite different, and I am not aware that any one, until now, has formally laid down the principle that an injection should be aseptic, nor urged that careful precautions should be taken in order to assure asepsis. While many injections recently recommended have for their base antiseptic substances, the object has been to destroy the pathogenetic microbe of gonorrhœa and not to obviate the danger resulting from the penetration of morbid germs. It is not sufficient to know that the bichloride or the permanganate will destroy the gonococcus, it is also necessary to recognize the fact that an injection, regarded as inoffensive, may constitute a source of danger.

I have examined, from a microbian point of view, a large number of specimens of urine in cases of cystitis consecutive to gonorrhœa. In the pus of some of these cases of cystitis, I have not found organisms, in some I have found the gonococcus, and sometimes I have found multiple varieties of organisms, most often bacilli of different sizes and diverse forms.

When we inquire into the history of patients of this last category, we find that during weeks and sometimes months they have been forcing into their urinary passages various injections. It is probably not necessary that the injections should have been passed beyond the anterior urethra in order to infect the deeper parts; in coition, for example, the gonococcus is certainly not deposited deep within the canal, but this does not prevent its progression, since it finds only a

feeble barrier in the urethral sphincter. It is not only necessary that the injections should not contain germs, but it is quite as necessary that the receptacle in which it is placed and the syringe with which it is used should likewise be aseptic. Preliminary boiling appears to be the best practical means of assuring the disinfection of the injection. Quite a number of efficacious agents in the treatment of gonorrhoea, as the sulphate of zinc, or tannin, or the salts of lead, are not antiseptic in the proper sense of the word. I think it prudent to even boil antiseptic solutions, since the proportion of the active substance must be feeble in order that the injection be not irritating.

It should not be forgotten that the solution is not deposited upon a healthy tissue, but upon a tissue swarming with microbes. Strong antiseptic injections are positively injurious, since they are always certain to irritate the membrane without ever being sure of destroying all the germs, and the germs which survive have in the inflamed tissues more favorable conditions of development. Another general principle in regard to injections is that they should contain no solid particle or at least only a state of extreme subdivision. One may readily conceive that a solid particle may lodge in an anfractuosity of the urethra and become the point of departure of a concretion.

Injections turbid and thickened with salts of lead or vegetable extracts are open, though in a less degree, to the same objections as the subnitrate of bi-muth.

Injections which do not stain the linen should, other things being equal, be preferred. Nitrate of silver possesses this inconvenience, and, moreover, it allows the deposition of a precipitate of chloride of silver, when brought into contact with the chlorides, but this precipitate, on account of its fineness, is not so objectionable, and, besides, the nitrate of silver possesses so positive an efficacy that we should continue to use it. I ought to add that I employ it rather in instillations than in injections properly so called.

#### THE PROPER TIME TO BEGIN THE USE OF INJECTIONS.

The general principle may be laid down that an injection, practised by the patient, is really efficacious and without objectionable results only when the disease is limited to the superficial portion of the anterior urethra.

The injection exerts a local action either in killing the microbes or in placing the tissues which contain them in a state unfavorable to the development and reproduction of the germs. There are two conditions in which this action is impossible: 1st, when the gonorrhoea has been propagated to the posterior urethra and the bladder; 2d, when the inflammation of the anterior urethra indicates that the disease is not confined to the surface of the mucous membrane, but has invaded the deeper tissue. But how shall we determine whether the gonorrhoeal inflammation has or has not penetrated to the posterior urethra? There are conditions in which this diagnosis is quite simple. A patient, for example, presents himself with a recent gonorrhoeal epididymitis, or an evident cystitis, characterized by frequency and pain of micturition and the expulsion at the end of urination of a few drops of blood. No one under such circumstances would prescribe injections. He should employ internal treatment, or have recourse to instillations of nitrate of silver, which sometimes give excellent results, especially in quieting the symptoms.

It may be laid down as a safe rule that, if the vesical urine is clear, the proper time for making injections has arrived; if the urine is turbid, it is better to wait.



The anterior urethra may be cleansed with the *sound à boule*, and then have the patient urinate, or to insure an absolutely exact diagnosis, *lavage* of the urethra is to be preferred. For practical purposes it will be sufficient to have the patient pass urine in a number of glasses. If only the contents of the first be turbid and the others clear, and if at the same time rectal exploration indicates that the prostate is neither swollen nor painful, we may infer a non-implication of the deeper parts and order injections.

A point of special importance should be here indicated : gonorrheal epididymitis is a very evident proof of profound propagation. Is it then necessary to await the complete resolution of the epididymitis before ordering injections? To this question we may answer, No ; it is only necessary, other conditions being favorable, that the painful period of the epididymitis be passed. Notwithstanding the persistence of epididymal induration, although it be somewhat sensitive, if we find that the vesical urine is clear, injections should be prescribed. It now remains to indicate the diagnostic signs of the inflammation being limited to the superficial portion of the mucous membrane. The most useful criterion is the absence of local signs of inflammation. To prescribe an injection when the meatus is red and swollen, when the discharge is yellow and abundant and tinged with blood, when the passage of the urine causes acute pain, while there is present œdema of the prepuce or sheath, is not only useless, but may cause an aggravation of the malady. When, on the contrary, the meatus has become pale, the discharge rather white than yellow and a little stringy, when the pain in urinating has ceased, when the local œdema has disappeared, when the palpation of the penis, and pressure exercised along the course of the canal, does not provoke pain, we may conclude that the anterior urethra is in a state to receive injections with advantage. One other point : At the *début* of the disease, within twenty-four or thirty-six hours after the first appearance of the discharge, there exists an apparently favorable condition for the employment of the abortive treatment by injections. Since Musitan, who employed calomel, numerous authorities have proposed formulæ for abortive injections, but the majority employ by preference nitrate of silver. I have not had occasion to employ the abortive treatment. This question of abortion should be determined from the absolute diagnostic point of view, which the presence of the gonococcus alone can give. I do not know of a single case of recent gonorrhœa where the diagnosis has been established by the microscope, and in which the abortive treatment proved successful.

#### HOW SHOULD URETHRAL INJECTIONS BE PRACTISED?

We have now principally in view injections practised by the patient himself and not by the surgeon. It may be necessary to carry a medicated injection into the posterior urethra or into the bladder, but this should only be done by the surgeon. The patient should never go beyond the anterior urethra ; the problem to be resolved consists then in finding the means which will enable the patient to carry an injection along the entire extent of the anterior urethra, comprising the cul-de-sac of the bulb, without penetrating the deeper parts. The syringes ordinarily employed for injections are too large. Four to five grammes of fluid are quite sufficient to fill the anterior urethra of the adult. This quantity should not be exceeded when the injection is practised in the ordinary manner with the meatus closed. The method which I recommend is to introduce a small supple tube of rubber, twelve to fourteen centimetres in length, size No. 10, scale of Charrière.

This tube, not greased, but simply moistened in the injecting fluid, is gently introduced, with the fingers clean and well washed, and carried nearly to the bottom of the anterior urethra. It should project one or two centimetres from the meatus, the point of the syringe filled with the injection is fitted into its external orifice, and the fluid is forced through the tube, *care being taken to have the meatus open*. The fluid necessarily passes to the bottom of the anterior urethra and passes out freely through the meatus, coming in thorough contact with every portion of the canal. The suppleness of the tube does not permit it to readily pass the urethral sphincter, and the injection made with the meatus open is not forced beyond the sphincter.

By employing injections in this way, neither microbes nor foreign bodies are introduced into the urethra, and the local action of the remedy is directed to the seat of the disease without exceeding its limits. These simple ideas have never before been formulated. The treatises on venereal are full of the most varied formulæ, but we vainly search for precise rules of practice in the employment of injections.

Injections employed according to the conditions I have indicated have a positive effect in shortening the duration of gonorrhœa, without exposing the patient to certain accidents with which they have sometimes very justly been reproached.—M. AUBERT, *Lyon Médical*, Jan. 3 and 10, 1886.

### CONTRIBUTION TO THE STUDY OF QUININE ERUPTIONS.

1. QUININE employed internally can at times produce eruptions.
2. These eruptions take on a multiplicity of form, of which one, the scarlatini-form, is of peculiar interest. These eruptions appear suddenly, become general with great rapidity, and are most frequently fugacious.
3. They may, in certain cases, be preceded by general phenomena of marked intensity.
4. They recur with the greatest facility under the influence of a renewed dose of the medicine.
5. The diagnosis may be obscured by the striking similarity of the scarlatini-form exanthem to that of certain eruptive fevers; and, to remove all doubt, you must, above all, take into consideration the fact of the recurrence.
6. The eruptions are extremely benign, and disappear generally in a day, exceptionally remaining several days.
7. They can be explained either by the elimination of the quinine through the sudoriparous glands, or by a special action which this drug has upon the circulation of the skin through the nervous system, and especially the vaso-motor nerves.—P. LAVASSAR, *Thèse de Paris*, 1885.

### MELANOSIS OFTEN NOT BLACK: MELANOTIC WHITLOW.

WHEN melanosis fungates, and when it affects the glands, we must not expect the larger growths to be of a black color. The power of producing black pigment appears to be, in most persons, very limited. The original growth, beginning it may be in the rete of the skin, or in the choroid of the eye, is coal-black, but the later and larger growths are white, or show only here and there a pigmented streak. To make the diagnosis at these stages, it is necessary to look carefully at the skin near the margin of the fungus. Here a little colored border may often be found, looking as if lunar caustic had been applied, which tells the tale.

*Melanotic Whitlow*.—There is a rare form of disease of the nail-bed which is malignant, and usually takes the type of melanotic sarcoma. It is generally at-

tributed in the first instance to injury, and its diagnosis is always missed in the early stages. Because it resembles whitlow, and is usually so named at first, I prefer to give it that name. It is, however, from the beginning, malignant. Careful observation will find at the edge of the inflamed nail a little border of coal-black color, and this, however slightly marked, must be allowed to make the diagnosis. I have seen at least half a dozen of these cases. Early amputation is demanded.—J. HUTCHINSON, in *Brit. Med. Jour.*

### SQUAMOUS ROSEOLA IN ITS VARIED FORMS.

1. THE entire group of features presented by the affection to which Gibert has given the name of pityriasis rosea permits us to consider it as a pseudo-exanthem more closely allied to the eruptive fevers than to the dermatoses with which it was formerly classed.

We believe that we should consider it as a special morbid entity, to which the name roseola squamosa would be applicable.

2. It is important, as well from a diagnostic as from a therapeutic point of view, to be perfectly familiar with the mode of production of the successive blotches which, almost of themselves alone, constitute the disease, and present in their evolution the varieties of form and configuration.

3. The mode of production is cyclic and distinguishes this affection from the chronic and parasitic dermatoses with almost analogous lesions.

The furfuraceous desquamation, which led to its being first described as a variety of pityriasis, should be considered as secondary.—ALBERT CHAPARD, *Th. de Paris*, 1885.

### RHEUMATIC PURPURA.

1. THERE exists a purpura of rheumatic nature which is a manifestation of the general rheumatic disease, in the same way as endocarditis, pleuritis, and polyarthritis may be.

2. This purpura is at times simple and at times hemorrhagic. This important distinction, for purposes of prognosis, is, in rheumatic purpura as in purpura of other origin, without consequence as regards nosology.

3. Simple rheumatic purpura is by far the most frequent.

Its duration and extension are very variable. At times a simple epiphenomenon, it may pass unperceived; at other times the exanthem attracts more attention than the rheumatism. In the latter case, the clinical picture is that of the *peliosis* of Schönlein and Fuchs.

4. To establish the rheumatic origin of certain purpuras, we have only taken the cases in which the joint affection was well marked, but it is proper to admit that a rheumatic purpura could exist without polyarthritis.—R. TEIXEIRA, D'AS-SUMPÇÃO, *Th. de Paris*, 1885.

### SCLEROSIS OF THE EXTERNAL FEMALE GENITAL ORGANS.

PROF. BREISKY has made some observations on a new disease of the external genital organs in the female, characterized by a sclerosis and consecutive retraction of the integument. The changes may sometimes go on to such an extent that the nymphæ become gradually atrophied, and finally disappear altogether, simulating, if seen then for the first time, a congenital malformation of the parts. The affection begins in the fold where the labia minora unite with the clitoris, invading then the labia minora and possibly even the majora. As a consequence a stenosis of the vaginal orifice results at the level of the vestibule. When the dis-

ease has progressed to a less extent, it is characterized by a hardness and dryness of the skin and thickening of the epidermis.

Up to the present time the author has collected a dozen cases of this singular affection. He has only once succeeded in making an anatomico-pathological study of a case in which he found a true scleroderma. The papillary portion of the skin is especially subject to this sclerotic transformation,—*Rev. des. Malad. des Femmes*.

### RETRACTION OF THE PENIS.

THE following remarkable case is referred to in the *London Medical Record*, February 15, 1886:

A strong man of 33 came to a local hospital in the Samara Government with a string encircling the retro-glandular sulcus of the penis and firmly fastened to the thigh. When the string was untied the penis slowly retracted, and ultimately disappeared under the pubic arch, leaving only a navel-like depression.

Coaxing and threats were of no avail; the organ would not present itself to view again until traction was made upon the string. The condition had been discovered five days previously by the patient, who, having got up to micturate at night, was surprised and shocked at his inability to find any organ with which to perform the act, being well aware of its existence at bed-time. After long and patient manipulation, he succeeded in bringing it to view, and at once secured it with a strong string, not wishing to risk its permanent withdrawal. There was no perineal pain, and no cause could be assigned for the strange retraction. Ten-grain doses of bromide of potassium were given every three hours. The following day the penis remained unretracted for an hour. Six days later the retraction disappeared and did not return. Dr. Ivanoff, who reported the case, could find no similar one in literature.

### GANGRENE OF THE PENIS.

ORLOWSKI reports in the *Gaz. Lekarska*, No. 32, 1885, the case of a patient aged 32, who had congenital phimosis, and for a year had not had connection.

Fourteen days before his admission to hospital, a small sore appeared on the prepuce and the salivary secretion was increased.

Gangrene of the prepuce and glans came on in spite of various treatment, and at date of admission one-third of the organ was in a gangrenous condition. The gums were indicative of scorbutus, and the lower extremities were covered with scattered petechiæ.

In the course of twenty-five days, one-half of the penis fell off, and the stump healed, leaving a cicatricial stricture of the urethra. The author had observed one other similar case in a robust young man in whom there were no signs of scorbutus.

### COCAINE IN MERCURIAL STOMATITIS.

IN this painful affection which sometimes compels a suspension of treatment with mercury, Dr. M. Bockhart has found the hydrochlorate of cocaine in 5% and 10%-strength of great service. It is to be applied to the gums with a camel's-hair brush about five minutes before each meal, and will enable the patient to chew his food without pain. In some very bad cases it may be necessary to use a 20%-solution ten minutes before meal times, and repeated in five minutes. He directs that the brush be always disinfected with carbolic acid after use, as the bacteria from the mouth adhering to the brush very soon spoil the cocaine solution.—*Monatshft. f. prakt. Derm.*, Feb., 1886, f. 67.



### JOINER'S VARNISH IN BURNS AND SCALDS.

DR. KRASSOVSKY, of Yaransk, Viatka Government, reports (*Proceedings of the Viatka Medical Society*, Nos. 10, 11, and 12, 1885, p. 18) that in two cases of burns of the second degree, he has obtained excellent results from repeatedly painting the parts injured with the common alcoholic varnish used by joiners. Pain immediately disappeared, and when the film of dry varnish fell off, it left the sound skin covered with epidermis. The author concurs with Dr. Svislovsky in that this plan of treatment is applicable only in cases where the cuticle remains unbroken. The author borrowed the use of varnish in burns and scalds from popular medicine, the method being extensively practised by peasants and artisans of the Yaransk district.—*London Lancet*.

### ICHTHYOL IN SHEETS.

DR. GÉCÉ has devised a means of applying ichthyol which appears to have many of the advantages of the "fixed adhesive dressings," being protective, supple, adherent, easy of application, and not requiring frequent renewal. It is made in thin sheets, which are directed to be cut into strips, moistened in hot water, and applied to the diseased part. It adheres perfectly, and forms, as it were, an artificial epidermis. Its renewal is required every three or four days.—*Gazette des Hôpitaux*.

## Review.

THE STUDENT'S MANUAL OF VENEREAL DISEASES. By BERKELEY HILL, M.D., and ARTHUR COOPER, M.D. Fourth Edition, revised. Philadelphia: P. Blakiston, Son & Co., 1886. 12mo, pp. xiv., 132. Price \$1.00.

THE fourth edition of this little book attests its popularity. It is a practical, concise treatise, written in an attractive style; a very readable book. Two-thirds of its pages are devoted to syphilis, the remainder being given to chancre, gonorrhœa, and accessory venereal disorders. We note that the term "*chan-croid*" is not used, "*chancre*" being the proper name for this lesion; while what we commonly call chancre in this country is rightly spoken of as the "initial" lesion of syphilis. We regret to see the terms "*leprous syphilide*" and "*lepra*" of the palms and soles, used on page 33; a misuse of terms that is confusing, and should be allowed to sink into oblivion, "*squamous syphilide*" being an infinitely better name. The authors take a cheerful view of the course of syphilis, and teach that the great majority of cases subside completely within two years, many ending spontaneously. In the treatment of this disease, we are told that the red or biniodide of mercury is specially useful in relapses of the scaly eruptions on the skin; and the green or protiodide sometimes fails to produce any effect, and is apt to cause griping and purging. It is advised to administer the iodide of potassium with the aromatic spirits of ammonia to increase the activity of the iodide and prevent its depressing effect.

Mention is made of the *bacillus* of syphilis and the *gonococcus* of gonorrhœa, though they are not recognized as proven. Otis' coil is recommended in the treatment of rupture of the erectile tissue of the penis. At the end of the book we have directions for the mercurial vapor-bath, and for making urethral injections. Also a number of formulæ which the authors have found useful. The book is a credit to the publishers, as it is printed in clear type and neatly bound.

G. T. J.

## Items.

**BROKEN GLASS IN THE VAGINA.**—A lady, aged 47, came to Dr. Angus on account of a displacement of the womb. Vaginal examination showed a hard round body lying to the right and posterior side of the cervix uteri. After some difficulty he succeeded in dislodging it, and found it to be the broad perforated end of a broken glass female syringe. The patient was amazed, and said she remembered, *seven months previously*, breaking a syringe when using a vaginal injection, but, hearing her husband coming up-stairs, she put the fragments into the chamber-vessel, and thought no more of it. Connection had taken place several times, the husband complaining of feeling some obstruction, but the patient had herself never experienced any inconvenience.—*Brit. Med. Journal*.

**EARLY GONORRHOEA.**—Dr. E. B. Ward, of Greensboro, Ala., reports two cases of early gonorrhœa in negro boys, aged 7 and 9 years respectively. Dr. Fenn, of San Diego, Cal., writes to the *Journal of the Amer. Med. Assoc.*, Dec. 12, 1885, that he has recently treated a lad of five years for undoubted gonorrhœa, who acknowledged that he had been toying with a dissolute girl of about twice his own age.

**THE CONSEQUENCES OF PHIMOSIS.**—Most text-books merely point out the possible danger of a phimosis causing distention of the bladder from the unnatural impediment to the outflow caused by it, and consequent implication of the pelvis of the kidneys through the ureters.

Dr. Hans Schmid has called attention (*Centralb. f. Chir.*, 28, 1885) to the frequent coincidence of inguinal, crural, and umbilical hernia, prolapse of the rectum, hydrocele, and, especially, obstinate eczema and intertrigo with this condition.

**HORNY GROWTH AT THE EXTREMITY OF THE PENIS.**—The *Indian Med. Gaz.*, Jan., 1886, gives an account of a Hindoo, aged 60, who had had gonorrhœa followed by phimosis fifteen years ago. Circumcision had been performed, in consequence of preputial irritation, eight months previously, and the growth had developed since then. There were two well-marked horny projections growing from the corona glandis, and the surface of the glans was covered with a cap of similar material. Amputation of the glans, including the growth, was performed with satisfactory result.

**CATHETERISM ALMOST PAINLESS.**—Dr. John A. Stamps recommends (*Medical and Surgical Reporter*) the following as an almost painless method of catheterizing an hyperæsthetic urethra: Inject through the catheter, as it is being introduced, water as warm as the patient can bear. The water regurgitates between the catheter and the urethral wall, and the warmth of the water will, in many instances, serve to allay all urethral irritability.

**GONORRHOEAL WARTS.**—Nusbaum washes gonorrhœal warts twice daily with salt and water, and then sprinkles them with calomel. The reaction of the residual sodium chloride and calomel produces mercuric chloride. This treatment, he claims, cures the warts rapidly, without causing pain or detention from business.—*Med. and Surg. Reporter*.





Fig. 1.



Fig. 3.



Fig. 2.



Fig. 4.

1. Variola. 2. Scarlatina. 3. Rubcola. 4. Roseola.



# JOURNAL

OF

## CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

JULY, 1886.

No. 7.

---

### Original Communications.

---

#### AN ADDITIONAL NOTE ON DOUBLE COMEDO.

BY

A. H. OHMANN-DUMESNIL, A.M., M.D.,

St. Louis, Mo.

THE February number of the JOURNAL contained an article, written by me, descriptive of a form of comedo hitherto unmentioned. Two cases were described at that time, and there were several points which required elucidation. Since that time, I have observed two more cases, and they throw some little light on a few of the obscure points mentioned before. A brief record of these cases may not prove uninteresting and is introduced, so that the contrast afforded by these with the first two recorded may be more easily seen.

CASE I.—A. U—— is about 19 years of age, rather inclined to a light complexion, and rather slight in build. He has never suffered from any other skin disease, nor did he ever have syphilis. He seems to be fairly well nourished, complaining only of constipation in a moderate degree. For the past six months or so he has been troubled with comedo, accompanied by a mild eruption of acne. The comedones are, for the most part, small, and the plugs inspissated to a high degree. The regions chiefly attacked are the hairy portions of the face, about the alæ of the nose, and along the border of the scalp, the ears being also implicated. Milium also exists to a limited degree. Improvement has been marked under a treatment consisting of laxatives internally and Unna's acid paste alternated with hot water applications, followed by a sulphur ointment, together with the daily expression of comedones. The double

comedo, which is present, is analogous to that observed in the next case, and will be described more in detail later on.

CASE II.—H. G.— is 21 years old, rather heavy-set, and of a lymphatic temperament. He is a blonde, and of German extraction. He has never had any skin disease anterior to this one, and never had syphilis. Some six months ago I treated him for a chaneroid, which rapidly healed. He is well nourished, and all of the functions of his organism apparently properly performed. He is troubled with comedo of the face, the comedones being fine and discretely distributed over the face. The same local treatment was ordered as in Case I. Although the trouble had lasted nearly a year before I saw him, the progress toward recovery was very satisfactory, and he will probably be entirely rid of the comedo in a comparatively short space of time.

CASE III.—T. J. W.—, aged 52, has had comedo for a long number of years. He has never been troubled by any other affection of the skin with the exception of rosacea. He has always enjoyed the best of health, and has never done anything for the comedones except pressing them out. He is almost entirely rid of them, but here and there can be seen double comedones, which are similar to those existing in Cases I. and II., and which have been described in a former paper.

In all of these cases the double comedones occur upon the face, and their site of predilection is near or about the malar eminences. Each opening is separated a little more than one-sixteenth of an inch from its fellow, the bridge of integument between the two being quite firm and well developed. Upon exercising pressure laterally, the plug is easily expressed and found to have both extremities black. A fine probe is readily passed through the opening thus left, and the existence of this horizontal tunnel clearly demonstrated.

These cases are interesting, as they elucidate at least one point, viz., that this condition of the tissues is not pathological, that it is an anomaly due to no destructive process, and that syphilis plays no part whatever in its production—a point which could not be definitely settled by the first two cases observed.

Again, in the first two cases, the condition was observed upon the back, whilst in those just recorded it is observed in the face.

I have come to the conclusion that double comedo is not, by any means, an uncommon thing, and that if observers will take a little more pains in examining the cases of comedo which come in their hands, they will soon note its comparative frequency. As to the true anatomical condition of the parts involved, I am unable to furnish any information at the present time. I, however, expect before long to obtain specimens from which sections can be made, and the relations established between the ducts of the sebaceous gland and these double openings upon the

surface. Should I succeed in this, it will form the basis of a note which will fittingly conclude the subject, which has so far elicited but little attention.

903 OLIVE STREET.

---

## ARSENICAL ERUPTIONS.<sup>1</sup>

BY

PRINCE A. MORROW, A.M., M.D.,

Clinical Professor of Venereal Diseases in the University of the City of New York, Surgeon to Charity Hospital.

THE cutaneous eruptions which follow the external and internal use of arsenic are similar in character. While the external contact of arsenic produces certain changes in the skin which can in no way be distinguished from a dermatitis caused by other local irritants, the severer eruptive forms are probably due to absorption of the drug, and its specific action through the blood upon the skin. The irritant effect of the external application of arsenic was known to the writers of antiquity, and has since been studied by numerous observers.

If arsenious acid in a watery solution, or in the form of an ointment or paste, be applied to the healthy skin, there results inflammatory redness, and, if the contact be continued sufficiently long, vesicles, pustules, etc., will form, attended with sensations of heat, burning, and pain, precisely as in the application of other vesicants. The hairs on the affected surfaces generally fall out, and there is exfoliation of the epidermis in large flakes. A higher degree of inflammatory disturbance is manifest in the production of erysipelatous swellings, sanguinolent eruptions, and ulcers, attended with toxic effects similar to those consequent upon the internal administration of the drug. Numerous cases are on record where arsenical lotions, plasters, and pastes have proved fatal. The application of an arsenical ointment (1 to 32) to a cancerous breast covering the space of one and one-half inches, for one night only, caused death from poisoning on the second day. A strong application of arsenic is much safer than a weak one, since the intensity of the inflammation it excites interferes with the action of the absorbents, and the effect remains local.

Abundant opportunities for the study of the changes in the skin caused by external contact have been afforded by the extensive use of arsenic in the form of lotions for the complexion, dusting powders, etc. A remarkable skin affection which prevailed among infants and children in

<sup>1</sup> From a forthcoming work on Drug Eruptions. Wm. Wood & Co., Publishers, New York.

Brighton in 1818, at first thought to be erysipelas, was traced to the use of a dusting powder containing fifty per cent of white arsenic. Of twenty-nine attacked, thirteen died. The cases were carefully studied by W. H. Power,<sup>1</sup> and the character of the eruption may be briefly described as follows: In very mild cases there was erythema and the formation of minute vesicles; in severer cases blisters and bladders formed in the creases of the skin where the powder was applied, some of the bullæ, when collapsed, left black excavated sores, with indurated and discolored edges. In fatal cases there was a generally blackened condition of the skin of the groins and pudenda, which quickly became somewhat swollen and hard. A like condition upon the abdomen was occasionally observed about and below the umbilicus, as also the skin of the axilla and folds of the neck. Invasion of these several parts where it occurred was simultaneous. In some instances vesication, variously described as "little white blisters," "yellowish bladders," or "bags of water," preceded or appeared about the same time as the blackness. The vesicles breaking discharged clear fluid and left raw black surfaces, which did not, it would seem from the description, take on suppurative or sloughing action. The average duration of the fatal illness was four or five days. The eruption was localized on parts of the body to which the powder was applied.

The various industrial uses of arsenic in the manufacture of artificial flowers, green-colored cards, paper boxes, wall paper, and carpets, fixing dyes, etc., are the prolific source of numerous forms of eruptive disorders.

It is well known that persons who wear cheap underclothing colored with fuschine, containing a large percentage of arsenic, or socks died with the same material, are subject to eczematous eruptions on the parts exposed to contact with the coloring matter. Seifert<sup>2</sup> reports the case of a lady who had been wearing stockings colored with an aniline red containing arsenic. She was suddenly seized with all the symptoms of a gastro-enteritis and an acute hemorrhagic nephritis, besides an eczematous eruption on the dorsal surfaces of both feet. The urine for some time afterward contained a small amount of albumin. Impetiginous eczema has been seen on the arms of a lady who wore a bracelet composed of a paste containing a large proportion of arsenite of copper. According to Rollet,<sup>3</sup> who has made a careful study of the cutaneous lesions from the industrial uses of arsenic, erythema is the first degree of arsenical dermatitis. Generally upon the erythema are devel-

<sup>1</sup> Power, W. H., "Rep. Med. Off. Local Government Board," London, 1879, p. 31.

<sup>2</sup> Seifert, Wiener Med. Wochenschrift, 1885, No. 38.

<sup>3</sup> Rollet, Annales de Dermat. et Syph., Tome I., 1880, p. 1.



oped other elementary lesions; papules which enlarge and extend and are covered with small scales of greenish tint, fine, transparent vesicles, and finally pustules. These pustules form with conical projections, red at the base, purulent at the summit, and are covered with a small opaque, yellowish-green crust. If the irritation continues, the pustules become the points of departure of ulcerations, which progressively increase in breadth and depth. Arsenical eruptions are situated upon parts exposed to contact with the irritating cause, as the face, forearms, hands, interdigital spaces, also the feet and inguino-scrotal region. The genital parts are peculiarly susceptible to the irritant action of arsenic. Frequently there are large ulcerations with œdema of the scrotum.

I observed several years ago at the New York Dispensary an eczematous eruption, with deep-seated pustules, on the hands of two young women who were employed in a paper-box manufactory, in which variously colored glazed papers were used.

White<sup>1</sup> reports several cases of arsenical dermatitis, one of intertrigo in an infant, and brown spots resembling pityriasis maculata et circinata of the mother, which were probably due to absorption of arsenical pigments contained in the wall paper, as every other possible factor was eliminated—a theory sustained by the fact that there was immediate improvement upon removal of the patients from the room. Clarke<sup>2</sup> records eczematous eruptions and nasal ulcerations as due to the emanations from arsenical wall papers.

Devergie was the first to signalize the fact that cutaneous lesions may be caused by the internal use of arsenic. The most complete and careful study of the arsenical eruptions has been made by Imbert Goubeyre,<sup>3</sup> and embodied in his admirable monograph upon this subject. According to this authority, the pathogenetic influence of arsenic may be manifested in the form of papular, petechial, urticarial, vesicular, erysipelatous, and pustular eruptions. To these may be added an erythematous or scarlatiniform eruption, the occurrence of which has been attested by numerous observers.

The various preparations of arsenic differ in no sensible degree in their effects upon the skin, so that observations relating to arsenious acid will apply to Fowler's solution, the arsenite of soda, Asiatic pills, etc.

*The Erythematous Form.*—Although an erythema is the commencing stage of several of the forms of arsenical eruption, it rarely represents the acme or completion of the inflammatory process. Pereira observed in a gouty patient, after taking  $\frac{1}{6}$  gr. arsenious acid a day, on the third day an intensely red eruption on the face, neck, upper part of the body, and

<sup>1</sup> White, Boston Med. and Surg. Journal, Nov. 6, 1884.

<sup>2</sup> Clarke, British Medical Journal, Vol. 1, 1873.

<sup>3</sup> Imbert Goubeyre, "De l'action de l'arsenic sur la peau," Paris, 1871.

flexor surfaces of the joints, with œdema of the eyelids. The eruption disappeared between the third and fifth days, but desquamation in large flakes continued for nearly two months.

Macnab<sup>1</sup> has observed a rubeola-like exanthem in patients who had taken small doses of arsenic, three-drop doses of Fowler's solution daily for three weeks.

Hyde saw in a young woman who had taken only three medicinal doses of Fowler's solution, a light-red scarlatiniform blush, with few isolated vesicles, covering both shoulders, the eruption being present, but less distinct, on the hands and face. Piffard<sup>2</sup> gives numerous references of erythematous and rubeoloid eruptions consecutive to the internal administration of arsenic.

*The Papular Form.*—According to Imbert Gourbeyre, the papular form occurs as discrete, pin-head-sized papules, first in scattered groups, which unite later to form lenticular papules, occasionally large disseminated patches, which sometimes resemble a papulo-syphiloderm, although of a less coppery hue. The parts affected by preference are the face, neck, hands, and genital organs. The eruption usually disappears in five or six days, followed by furfuraceous desquamation. In one case the papules increased in numbers until they gave the skin the appearance of a "goose-flesh." The eruption was attended by decided itching, and lasted some days after the discontinuance of the medicine. Stewart<sup>3</sup> reports the case of a powerfully built man, who was ordered five-minim doses of Fowler's solution after each meal. After the sixth dose he felt feverish, and he noticed that his hands and arms were red, swollen, and very hot; the redness of the skin spread rapidly, until it involved the entire surface, except the face. The skin was covered with countless papules, about the size of millet seeds.

Keyes<sup>4</sup> reports after the use of arsenic, doses not stated, a papulo-erythematous eruption, dry and livid, on wrists and neck. General papular eruption on trunk and extremities attended with pruritus. Baglie observed dryness of the skin, heat, and itchiness of the eyelids with the production of a minute papular rash, followed by desquamation.

*The Urticarial Form.*—Fowler,<sup>5</sup> whose name is so well known in connection with this drug, in his medical reports on the effects of arsenic, was the first to instance urticaria as one of the results of its employment. According to Imbert Gourbeyre, it is one of the most frequent forms of arsenical eruption. The wheals are white or rosy-red, and extremely

<sup>1</sup>Macnab, Med. Times Gazette, London, 1868, 1, p. 297.

<sup>2</sup>Piffard's "Mat. Med. and Ther. of Dis. of the Skin," p. 24.

<sup>3</sup>Stewart, The Canadian Practitioner, April, 1885, p. 103.

<sup>4</sup>Cited by Piffard.

<sup>5</sup>Fowler, "Med. Reports of the Effects of Arsenic," Lond., 1786, p. 97.

pruriginous, differing in no essential particular from urticaria as commonly observed. Berenguier reports the case of a young lady treated with arseniate of iron, which brought out a copious eruption of white, somewhat reddish elevations of the uniform size of a lentil, and accompanied by intense itching.

*The vesicular form.*—The occurrence of a vesicular eruption from the ingestion of arsenic has been recorded by numerous observers. This eruption may sometimes assume an eczematous character which, according to Balfour,<sup>1</sup> may prove extremely obstinate. Ringer says eczema or urticaria may arise, or perhaps vesication or mere desquamation with tenderness of the hands and feet; again he says in arsenical poisoning a petechial papulo-vesicular or wheal-like rash often appears from the second to fifth day.

Finlayson<sup>2</sup> saw an eruption of clusters of vesicles on an inflamed base, extending from lower part of the arm down the back of the forearm and hand, including backs of the fingers. Herpes labialis and preputialis have also been observed from the use of arsenic. It has been asserted that herpes zoster may occur as the result of the ingestion of arsenic in medicinal doses. Hutchinson,<sup>3</sup> while not claiming that a causal connection has been absolutely demonstrated, yet suggests its extreme probability in view of the well-known fact that herpes zoster has been more often observed in patients who have been taking arsenic than in those not subjected to this medication. He reports a number of cases, fifteen or sixteen, in which the coincidence was so marked as to furnish strong presumptive evidence of an etiological relationship. His observations have been supplemented by the experience of many other dermatologists who have noted this coincidence.

*The pustular and ulcerative forms.*—According to Imbert Gourbeyre, the internal use of arsenic may produce a pustular eruption resembling variola, the lesions terminating in crusts or ulcerations leaving cicatrices.

Orfila has noted, as one of the toxic effects of the drug on the cutaneous system, an eruption of pustules on the face, shoulders, arms, and chest.

Bazin<sup>4</sup> reports a case in which there appeared after minute doses of arseniate of sodium, continued for fourteen days—one-half of a grain altogether—an eruption of discrete pustules in various stages of development, limited to the hypogastrium and right flank. One of the pustular le-

<sup>1</sup> Balfour, Edinburgh Med. Journal, 1860.

<sup>2</sup> Finlayson, The Practitioner, London, July, 1878, p. 18. "Occurrence of herpes during administration of arsenic."

<sup>3</sup> Hutchinson, St. Barthol. Hosp. Rep., Vol. ix.

<sup>4</sup> Bazin, "Leçons Theoret. et Clin. sur les Affections Cutanées Artificielles."

sions has become transformed into an ulcer, a centimetre in diameter, surrounded by indurated and inflamed tissue. Near by were two large erythematous pustules just breaking down in the centres into ulcers; other lesions were passing from a papular into a pustular form. The evolution of the lesion through its various stages, from appearance of papule to cicatrization of ulcer, occupied only a few days. The patient rapidly recovered as soon as the arsenic was stopped. In this case, as in others, pustular lesions are the points of departure of the ulcerations encountered in various parts of the body, more especially in the head, limbs, and scrotum. Gangrene sometimes occurs around the genitalia.

Erysipelas with bullæ, erysipelatous inflammations about the face and eyelids, and eruptions of a petechial character, affecting by preference the trunk and genital parts, have been recorded by Bazin, Imbert Goubeyre, and others.

According to Morris,<sup>1</sup> boils and carbuncles occasionally result during a course of arsenical treatment. This statement is confirmed by Foster, Vaudry, and others cited by Piffard.

*Brownish pigmentations.*—Among the incidental effects of arsenic upon the skin may be mentioned certain grayish or brownish discolorations, which are especially liable to occur upon the face and various parts of the body, after its prolonged use. Wilson<sup>2</sup> reports the case of a patient with gutta serena, who had taken arsenic for two months, when there was noticed a change in the color of the skin, first over the abdomen, then on the neck, breast, face, and hands. The face was of a yellowish-brown color, the eyeball dark, the skin of the entire body more or less pigmented; chronic erythema affected the palms; there were hard dry points at the orifices of the sweat glands; the eyelids and the extremities were oedematous. In the June number of this JOURNAL will be found a case of arsenical dermatitis presented by me before the New York Dermatological Society. There was an erythemato-papular eruption, with a grayish-brown, almost black discoloration of the surface, especially marked over the abdomen and inner surface of the thighs. Guailo reports that, in fourteen children placed upon Fowler's solution for four or five months, there was observed a bronzed appearance similar to that of Addison's disease, beginning on the neck, extending to the chest, then to the abdomen and hands; at times it is seen on the back and legs. It disappears by desquamation in about four weeks. Bazin has characterized this pigmentation as a tint, comparable to the staining of nitrate of silver. This condition depends, according to Gubler, not upon a chemical combination, as is the case in argyria, but on abnormal pigmentation. Wyss<sup>3</sup>

<sup>1</sup> Morris, Malcom, Practitioner, 1880, p. 434.

<sup>2</sup> Wilson, Journal of Cutaneous Medicine, Vol. 1, p. 354.

<sup>3</sup> Wyss, O., Archiv für Heilkunde, Bd. xi., 1870, p. 17.



saw alopecia areata developed by the prolonged internal use of arsenic. This result he thought due to the effect of the drug upon the trophic nerves of the hair follicles, causing disturbance of nutrition.

As regards the pathogenesis of arsenical eruptions, opinions differ. It is known that arsenic is eliminated not only by the kidneys, but by the glands of the skin, the mucous membranes, the salivary lachrymal glands, etc. Chatin<sup>1</sup> found arsenic in the contents of a bulla, and Bergeron and Lemattre<sup>2</sup> in the sweat of patients undergoing arsenical treatment; while Barella<sup>3</sup> claims to have demonstrated the direct elimination of arsenic by the sweat glands. Therapeutically, arsenic has been classed as a neuro-tonic and is supposed to modify cell nutrition through its influence upon the peripheral nervous plexuses. In view of these facts, we can understand how it may cause disorders of the capillary circulation and disturbances of the nutrition of the skin, as manifested in the various forms of eruptive disorder above described.

The treatment of arsenical eruptions may be restricted to the simple expedient of suppressing the offending cause. In the more severe forms, the same local measures are to be resorted to as are indicated in dermatitis from other causes.

66 WEST 40TH STREET.

---

## DERMATOSES OF THE EYE.

BY

CHAS. W. ALLEN, M.D.,

Surgeon to Charity Hospital.

(Continued from page 171.)

### BENZOL IN EPITHELIOMA OF THE EYELID.

AT the April meeting of the New York Ophthalmological Society (*N. Y. Med. Journ.*, Sept. 26, 1885), Dr. Mathewson presented a case of epithelioma of the right lower lid, which he had first seen two years before, and had treated with applications of benzol. The tumor had begun as a warty excrescence one or two years before it came under treatment. The benzol was applied three or four times a week for about three months, when the growth had completely disappeared, leaving a smooth, depressed cicatrix.

In March, 1885, the man returned with the history of a small ulcerating spot having appeared some six months before at the outer edge of the cicatrix. When presented at the meeting in April, this had greatly

<sup>1</sup> Chatin, *Journal de Clinique Medicale*, 1848, p. 328.

<sup>2</sup> Bergeron and Lemattre, *Archiv. général. de Méd.*, 1864, II., p. 173.

<sup>3</sup> Barella, *Journ. de Med. de Bruxelles*, Juillet, 1863.

improved under the same treatment. By May 1 it was nearly well again, but treatment was neglected, and by July there was considerable increase in the ulcerating surface. Benzol was now applied again from two to four times a week, and the disease yielded promptly to the treatment.

#### SEBACEOUS TUMOR OF THE LOWER LID.

Prof. Richet (*Gazette des Hôpitaux*, No. 67) recently operated on a sebaceous tumor of the lower lid of a young man, which had begun to form at the ciliary border, five and a half years before. Three years ago, it had been removed, but reappeared one year later.

It was the size of a hazelnut, and interfered with patient's comfort. A plastic operation was necessary to prevent cicatricial contraction.

The author had found in several similar tumors sarcomatous elements, and cited one case where the removal of what appeared to be a simple sebaceous cyst of the nose was followed by similar sebaceous-like growths in other parts, and finally by a generalization of the neoplasm and death; and thought perhaps sarcomatous elements might be found in this tumor to account for its recurrence.

#### XANTHELASMA.

Whenever the term xanthoma or xanthelasma is mentioned, we instinctively think of the eyelids. The disease is, however, not confined exclusively to this organ, and I have seen it affecting several other regions. Hardaway, Robinson, Barlow, and others have recently reported cases in which the disease appeared on the trunk and extremities. Still the lids are the seat of the deformity in by far the greater number of cases, without our being able to give any good reason for the fact. Indeed, we don't know much about the disease, at best. In my experience, it occurs more frequently in women than in men, and I have seen it in diabetes, in which disease it is said to be quite common. It has been supposed by many to have some connection with liver disorders, and Hutchinson has shown its pathological relations with icterus and arthritis.

A review of the study of the disease by Dr. Carlo de Vincentiis, of Palermo, will be found in the *Annales de Dermat. et de Syphilig.*, 1884, p. 80. He believes, from his examination of tumors removed from eyelids of a girl of 20, that the disease does not result from a fatty degeneration, as Baerensprung taught, nor from an inflammatory or infectious hyperplasia, as Balzer believed, nor yet that it is an hypertrophy, but that we have to deal with a true neoplasm.

In 1883, Balzer described microbes found in the granular matter of the tumors; but, so far as I know, they have never been shown to have a causative relation to the disease. He was led to seek for a cause in this direction

from the analogy existing between the disease and tuberculosis and leprosy, both of which have their bacilli.

Writers now generally agree that the disease consists in a new-growth. Robinson states that connective tissue forms the basis of the tumor in which fatty degeneration readily occurs.

Excision, carefully done to avoid ectropion, offers the best means of removal. Co-existing disorders, such as disease of the liver, diabetes, etc., should be discovered and treated. I have seen one case in a diabetic woman in which the tumor diminished as the diabetes improved. Legge has observed spontaneous resolution in a case. The administration of phosphorus followed by turpentine has, in the hands of Besnier, produced rapid disappearance of the tubercles.

#### MILIUM

or strophulus albidus is frequently found co-existing with xanthoma on the lids, and might be mistaken for it when large. Much more frequently, however, it is found alone. Though not confined to the eyelids, the growths are probably more often met with in this than in other portions of the face, and are more common in early childhood. Virchow regarded them as arising from the hair-follicles.

Robinson believes in some cases they are the result of miscarried embryonic epithelium from a hair-follicle, or from the rete. Most cases of milia, or the affection which commonly goes by that name, I believe are due to retention of sebaceous matter in the sebaceous glands and their ducts, and is closely allied to acne. The disease is readily cured by incising or puncturing each separate lesion, and evacuating the contents with a large comedo expressor, care being taken not to press upon the globe of the eye.

#### VESICO-PUSTULE OF THE LOWER LID AND ULCERATIVE KERATITIS FOLLOWING ACCIDENTAL VACCINATION.

The following rare and remarkable case is found in the January number of the *Recueil d'Ophthalmologie*:

An army surgeon, Dr. Senut, while engaged in collecting vaccine lymph from a heifer, had a few drops of pus to accidentally squirt upon the left eyelids from a pustule he was pressing. Four days later a papule appeared upon the lower lid and soon became a vesico-pustule, attended with œdema of lids and febrile movement.

Four or five days later the pustule ruptured, and was succeeded by an ulceration.

Three days later, a crescent-shaped ulceration appeared upon the lower part of the cornea. The intra-ocular tension became so great that paracentesis was at one time thought necessary. A cure was finally effected

by means of cocaine, atropine, and hot applications, but cicatrices were left upon both cornea and lid.

#### ECZEMA OF THE LIDS.

Eczema may attack the lids when the other regions of the face, and possibly of the body, are at the time entirely free. Such cases are at times regarded as blepharitis, but until the correct diagnosis be made and internal treatment combined with local means, the disease will prove rebellious. This disease is regarded by Dr. Burchard (*Monatshefte für Praktische Dermatologie*, No. 2, 1885) as a frequent cause of phlyctenular conjunctivitis and keratitis, and subsequent prolapse of the iris, partial destruction of the cornea, and consequent blindness.

The treatment consists in applying to the closed lids a three-per-cent solution of nitrate of silver, and drying immediately with a linen cloth, repeating the process several times at each sitting, all vesicles and pustules having been previously opened.

Applications are made at first each day, and, as improvement goes on, every second day. After a few brushings there is scarcely any pain.

An ointment composed of Ol. Cadini, 3 i.; Pulv. Zinci Oxidi, 3 iss., and Vaseline, 5 i., should be constantly applied in the intervals. If this ointment should prove irritating to the eyes, a mild white precipitate ointment may be substituted.

To this local treatment should be added tonics, alkalies, or such constitutional remedies as the case may indicate.

#### PEDICULI PUBIS.

*Pediculi Pubis* of the eyelids appears like a paradox. Still, the name is a proper one, for the crab louse does not confine himself to the region of the pubes any more than the pediculus vestimenti remains continually upon the clothing. It is extremely rare to find the eyelids infested with this parasite. I recently saw an instance in the case of a young girl at the clinic. She came complaining of itching and soreness of the lids. I looked carefully at her eyes, and told her she had suffered from itching about the privates for some time. She looked surprised, but said she had. I then told the students that the cause of this itching about the external genitals was due to crab lice. Looking into the eye and discovering pediculosis pubis was considered a brilliant diagnosis until I pointed out to them that a line of brown points along the edge of the lids between the lashes were really the parasites, and detached some of them from the hairs to which they were clinging by their powerful claws.

Treatment consists in the thorough application of a diluted citrine ointment to the lids, and removal of the parasites at the same time that



their destruction is accomplished on other regions of the body, with ointment or wash of staphysagria, carbolic, or one of the mercurials.

Many diseases of a constitutional nature having their most prominent lesions or manifestations upon the cutaneous surface, give also at times marked changes in the eye.

In lepra, for example, which has advanced to a considerable extent upon the skin, we at times find lesions of the cornea, and subsequently tubercles in the cornea.

The eye lesions of syphilis are so numerous and interesting that I shall reserve their consideration for some further notes at another time.

102 EAST 57TH STREET.

---

## Correspondence.

---

### A "TROUBLESOME CUTANEOUS DISEASE."

PORTSMOUTH, N. H., May 22, 1886.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

DEAR SIR:—There is a troublesome cutaneous disease, of an epidemic character, very prevalent in this section, and I do not know what category to place it under. It has the general appearance of an eczema papulosum, with violent itching, especially at night; but its principal characteristic is its contagiousness; whole families are affected with it. I have been consulted by patients as far east as Eastport, Me., who tell me a great many are afflicted by it in that neighborhood.

The first cases I saw during the winter, and called it *pruritus hiemalis*, ignoring its contagious character; but cases seem to be as frequent now as during cold weather, and I am puzzled as to the nature of the trouble. A simple ointment of ammon. hydrarg. seems to be the most efficacious remedy, but some cases resist this treatment. I hope that you or some one of your dermatological correspondents may throw a little light on this disease through the columns of your JOURNAL, for the benefit of yours very truly,

A. B. SHERBURNE.

The disease which puzzles our correspondent is probably identical with a pruritic affection widely prevalent in the West, and which in different localities has received the euphonious titles of "swamp itch," "prairie digs," "Ohio scratches," "Michigan itch," etc. It has been confounded with scabies, but positive evidence of its parasitic origin was not revealed by the presence of the *acarus* in any of the numerous cases examined. The failure of the time-honored remedy of sulphur and lard, with which patients were in many instances copiously anointed, also furnished negative evidence as to its parasitic nature. Presumptive proofs of its contagiousness were found in the fact that often several members of a family were attacked at the same time, or successively.

We think the original diagnosis of our correspondent correct. The "itching disease," above alluded to has been carefully studied by Drs. Hyde, Hardaway, and others, and its identity with *pruritus hiemalis*, or the winter prurigo of Hutchinson, has, we think, been conclusively established. It is due essentially

to climatic conditions, its advent is made with the cold weather, and it is more prevalent in localities where severe changes of temperature occur. The explanation of its apparent contagiousness, as in cases where entire families are simultaneously affected, may be found in the fact that all are equally exposed to the same atmospheric conditions.

It is proper to say that many observers do not recognize cold weather as the chief etiological factor in the production of this disease, but the theory is quite consistent with the facts of our knowledge respecting the influence of temperature changes in the causation and aggravation of cutaneous diseases. The direct irritant effect of heat and cold upon the skin is a matter of common observation. The action of heat is familiarly manifest in the production of sunburn, prickly heat, *eczema solare*, etc. Many of the cutaneous disorders which prevail among our tenement-house population in this city during the hot summer months are directly traceable to the extreme heat. Chapped hands and faces, and a general roughened condition of the surface exposed to the action of cold, are no less familiar phenomena.

In the disease under consideration, however, the primary influence of the cold seems to be limited to the production of an irritable condition of the skin characterized by intense pruritus, always aggravated at night. The papular, vesicular, or other lesions are secondary, and superinduced by irritation of the skin from scratching. In exceptional cases a dermatitis, presenting a clinical resemblance to papular or vesicular eczema, develops without antecedent history of pruritus. In aggravated cases, pustular and furuncular lesions may occur. An urticarial form has also been observed, which presents certain analogies with the urticaria of immigrants, so common in our sea-board cities, and which is recognized as due to a change of climatic and dietetic conditions.

The treatment should be local and directed principally to the mitigation of the subjective symptoms. Turkish baths constitute a most efficient means for the relief of cutaneous pruritus, but these are rarely available. Hot alkaline baths prepared by the addition of six or eight ounces of the bicarbonate of soda, employed at bed-time, afford great relief. After an immersion of fifteen to twenty minutes in the bath, the skin should be carefully dried and an inunction made with carbolized vaseline or a soothing ointment. The anointed parts may then be dusted with Pears' fuller's earth, a mixture of starch and rice flour, or any of the ordinary dusting powders. Lotions of carbolic acid (five to ten grains to the ounce; with a little glycerin) or an ointment of carbolic acid (fifteen to thirty grains to the ounce) have an excellent antipruritic effect. When the skin is not broken, painting the affected surfaces with a solution of carbolic acid in glycerin (thirty grains to 3 i.) will effectually subdue the itching.

The various preparations of tar which have a deservedly high reputation as antipruritics may be used either in solution or in the form of ointments. One of the best antipruritic ointments is one drachm each of camphor and chloral to the ounce of ung. aq. rosæ. Another preparation which I have found of great service in allaying itching is the following:  $\mathcal{R}$  Sodæ bicarb., 3 ij.; potassæ bicarb., 3 i.; glycerinæ, 3 ij.; tinct. opii, 3 iss.; aq., ad 5 viij. M.

The same preparation does not prove of equal efficacy in all cases, and when one fails, another may be found more serviceable.

Some of our Western confrères who have had a large experience in the treatment of this distressing affection may be able to give our correspondent therapeutic hints of more value.

EDITOR JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.

## BROWN DISCOLORATION FROM REPEATED EXPOSURE TO SULPHUR-VAPOR INSTANTLY REMOVED BY HYDROGEN PEROXIDE.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

DEAR SIR :—During April, 1886, Mr. X—, aged 21, came under treatment for scabies. Several years before he had contracted syphilis, and had been under specific treatment for a good part of the time since. Between his first and second visits he had drank heavily, neglecting treatment for his scabies, and ending his spree only upon the supervention of a series of epileptiform convulsions, the first he ever experienced. He was put upon sulphur ointment and sulphur baths, and, as he improved rapidly, and was especially anxious to be free from the disease at the earliest possible moment, he took a sulphur bath every other day, half a pound at a time. When virtually free from the scabies, and looking forward to an immediate return to his home in the country (he had taken some four or five baths), his hands suddenly assumed a deep brownish color, and while the tint deepened, it also extended up the arms. The bath-keeper told him it was a common occurrence; that there was no help for it; it would wear off in a fortnight, etc. This bath-keeper had been thirteen years at his business, and spoke so authoritatively that Mr. X— was much chagrined; still he besought me earnestly to try and remove it. After some simple measures, which produced not the slightest effect, I ordered him to apply hydrogen peroxide. First giving the parts a soaking with hot water and soap, he applied the  $H_2O_2$  with a tooth brush, and had the satisfaction of seeing the stain disappear completely in a single application.

EDWARD PREBLE, M.D.

4 EAST 37TH STREET.

## TREATMENT OF RHUS POISONING.

HURON, OHIO, June 7, 1886.

*Prince A. Morrow, M.D.*

DEAR DOCTOR :—I notice in the June number of your JOURNAL OF CUTANEOUS AND VENEREAL DISEASES various remedies given by you for the treatment of poisoning by Rhus toxicodendron. I have tried some of them formerly, but of late years I use lime-water and olive-oil in equal proportions, with a little carbolic acid, and I find this does better than anything I have tried yet.

Thinking this might be of interest to your correspondent, I venture to mention it.

Fraternally yours,

J. P. ESCH, M.D.

## REMEDIES FOR RHUS POISONING.

NEW YORK, June 12, 1886.

*Dr. P. A. Morrow, Editor Journal of Cutaneous and Venereal Diseases.*

MY DEAR DOCTOR :—In the June number of your very valuable JOURNAL I noticed a request by Dr. Tompkins, of West Virginia, that you give a reliable remedy for the treatment of the poisoning resulting from the Rhus toxicodendron. I observed that you supplied the request most ably and fully, but I beg you will permit me to offer one suggestion upon the subject.

Carbolized vaseline with cocaine will prove, I think, one of the very best dressings for the relief of the distressing burning and itching which is always present in these cases. The dermatitis resulting from the poisoning has been treated by me both with a solution and an ointment, at different times, made

after the following formulæ, with the most gratifying results, affording positive relief to the patient while under treatment :

R. Acid carbolic (crystals)..... ℥ 20.  
 Glycerite of cocaine, 4 per cent..... ʒ ij.  
 Vaseline..... ʒ i.

M. Sig. Ointment.

R. Acid carbolic (crystals)..... ʒ ss.  
 Glycerite of cocaine, 4 per cent..... ʒ iv.  
 Aq. Laurocerasi..... ʒ i.  
 Aq. Rosæ..... ʒ ij.

M. Sig. Lotion.

Either to be applied several times daily.

Respectfully yours,

J. BLAKE WHITE, M.D.

941 MADISON AVENUE.

## DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

### Scleroderma.

Dr. Radcliffe Crocker has published two excellent "Clinical Lectures on Scleroderma" (*Lancet*, Jan. 31, p. 191; Feb. 7, p. 237; May 23, p. 927, and May 30, p. 975). He describes diffuse symmetrical scleroderma by an account of four cases, of which three occurred in women. The first two cases are instanced as examples of the hypertrophic form of the disease, while the latter two were characterized by an atrophic condition of the affected skin, which he looks upon as probably a later stage of the pathological process in the majority of cases. He points out the frequent association of scleroderma with rheumatism and heart disease, but is disposed to believe that this is due to exposure to cold and wet in both cases, rather than to any special arthritic proclivity; in one patient subcutaneous nodules were found which exactly resembled in character and distribution those described by Drs. Barlow and Warner as rheumatic. The treatment recommended consists in good food and protection from changes of temperature, with ferruginous and other tonics and cod-liver oil. Shampooing after Turkish baths is also recommended, and treatment by galvanism receives mention. Dr. Crocker then passes to the consideration of the circumscribed form of the disease, to which the name morphea is commonly applied in England; he describes several cases, including a few in which the patches seem to have followed injury or friction by the clothes, and points out that the disease is not invariably distributed in the apparent course of nerves. A good account (illustrated by woodcuts) is given of the histological changes met with, and lastly, treatment is spoken of. This is unsatisfactory, as no internal remedy can influence the disease directly, and, he thinks, no local treatment has any good effect, but "any irritating application does harm, both in spreading and increasing the thickness of the patch." He thinks that galvanism of the neighboring skin might be tried, but would not recommend it over the patch itself; fortunately, however, recovery nearly always takes place in the natural course of the affection, although it may take many years. The lectures conclude with a description of the diffuse unsymmetrical form, which is of interest as forming a connecting link between the other two. The subject of "Scleroderma in Relation to *Filaria Sanguinis Hominis*" is treated of in a short communication by Dr. Bancroft (*Lancet*, Feb. 28, p. 380). He describes a case occurring in a young girl in Australia, and characteristically affecting the upper parts of the body, in which filariæ were frequently found in



the blood in large numbers. Dr. Finlayson has written "On the Occurrence of Symmetrical Gangrene of the Extremities in a Case of Scleroderma Adultorum" (*Med. Chronicle*, January, p. 315). The coincidence of these remarkable affections had already attracted the attention of Dr. Favier in France some years ago. A paper on "Diffuse Scleroderma," by Dr. Handford (*Lancet*, Sep. 26, p. 569), must also be mentioned. He gives a very full description of a case occurring in a girl at the unusually early age of 13.

### Rhinoscleroma.

At the meeting of the Pathological Society on March 3, Dr. Payne and Dr. Semon showed drawings and microscopical specimens from a case of this rare disease. The patient was a Guatemalan, aged 18; the disease had existed four years, and had begun insiduously, without known cause. There were two rounded reddish swellings, firm but not very hard, each about the size of half a hazelnut, and ulcerated on the surface, just below the nostrils, both of which were filled with similar masses. The bridge of the nose was considerably broader than normal, and the tissues of the nose beyond the bones were of stony hardness to the touch. The throat was also affected; the uvula had entirely disappeared, while on the soft palate an irregular, raised, whitish, slightly ulcerated patch was seen. The rest of the soft palate had undergone considerable cicatricial contraction, fibrous bands running from the ulcerated patch in all directions. Energetic antisyphilitic treatment was continued for some months, but with no result; the case was therefore treated by operation, the external tumors and the masses blocking the nostrils being thoroughly scraped out with the sharp spoon, and the exposed surface freely cauterized. In spite of these precautions, unmistakable signs of recurrence made their appearance two months afterwards. The whole histological structure was quite different from epithelioma, or sarcoma, or any other definite tumor-formation, but rather resembled the "granulation" tumors, such as lupus, syphilis, etc., though quite distinct from any of these. This patient had previously been in Paris, and while there, M. Cornil had an opportunity of examining the growth for micro-organisms; these were not at first detected; later, however, they were found, and Dr. Payne was able to demonstrate them at a later meeting of the Society. "A Further Note on Rhinoscleroma," by Dr. Morell Mackenzie (*Brit. Med. Journal*, March 21, p. 587) refers to the same patient, who was for some time under his care.

### Multiple Xanthoma.

A somewhat anomalous case of this rare affection is reported by Dr. Kent Spender (*Brit. Med. Journal*, March 7, p. 482). A lady, aged 30, was completely crippled by "chronic osteo-arthritis," which had existed about six years. About a year before she was seen, the skin of the soles began to grow yellow, and a year later brownish-yellow spots and patches, from one-eighth to one-fourth of an inch in diameter, appeared on the upper and front part of the right leg. The spots felt slightly raised. Subsequently the palms of the hands became tinted yellow, like the soles, and this color gradually became deeper and extended in area; it appears to have been diffused. As Dr. Spender says that "the nails of the left thumb and right great toe have separated from their respective phalanges, and are almost torn from the matrix by an increasing accumulation of dry chalky material," it would seem that true gout was to some extent responsible for the patient's condition. There had never been jaundice nor any other disorder of the liver, and the urine contained neither albumin nor sugar.

### Ringworm.

Dr. Foulis considers the following an effectual plan of treatment in ringworm of the scalp (*Brit. Med. Journal*, March 14, p. 536). The affected child, the hair being cut short over and around the affected parts, is seated before a basin half filled with warm water, and a folded towel tied round the forehead, so that no fluid poured on the head can trickle into the eyes. The child bends forward over the basin, and spirit of turpentine is freely poured over one or more spots at a time, and well rubbed into the scalp with the forefinger. This removes dirt and greasy scabs, and the short broken hairs are seen to stand up like bristles. In about three minutes smarting is complained of, showing that the turpentine has penetrated deeply. Carbolic soap is then immediately well rubbed in and made to lather by the warm water, the smarting soon subsides, and the head, being now beautifully clean, is dried. Compound tincture of iron, in two or three coats, is now painted well over the affected parts, and allowed to dry. Carbolic oil (1 in 20) is then rubbed into the rest of the hair when it is dry. This treatment, applied every morning, or morning and night in severe cases, generally cures the worst cases in the course of the week. (It is this method which has been found unsuccessful by Dr. Hallopeau and Laller in Paris. See this *JOURNAL*, February, p. 50. Dr. Foulis' name is misprinted 'Fontis.') Dr. Henry Browne (*Brit. Med. Journal*, June 6, 1885, p. 1,153) gives the following formula as having yielded perfectly satisfactory results.  $\mathcal{R}$  Sodæ hyposulphitis 3 i., solve in aquæ fl.  $\mathfrak{z}$  viij., et adde acidi hydrochlorici fl. 3 i., for outward use only. The lotion is applied on lint covered with oiled silk, and accompanied by daily washing of the scalp with soft soap and water. Dr. A. I. Harrison communicated a paper on "A New Method of Treating Tinea Tonsurans" to the section of medicine at the last meeting of the British Medical Association (*Brit. Med. Journal*, September 5, 1885), and published a note giving further explanations (*Brit. Med. Journal*, December 5, 1885, p. 1,059). This treatment, as finally modified, consists in the application, by dabbing on the scalp, of a solution of half a drachm of iodide of potassium to the ounce of a mixture of equal parts of liquor potassæ and spirits of wine, for three or four minutes at a time. When this has been done two or three times at intervals of two or three days, a solution of four grains of bichloride of mercury to the ounce of a mixture of equal parts of distilled water and spirit of wine is applied in the same manner, and on the first occasion ten minutes after the use of the potash and iodide lotion; afterwards it is used by itself two or three times at two days' interval. A few days are then allowed to elapse without the application of any remedy, and then the potash solution is applied once, and followed up with the mercurial solution at an interval of ten minutes. Dr. Harrison has treated many cases in this way with good results, and claims great penetration for the remedy, as the hairs are much softened by the potash, while the mercury is precipitated *in situ* by the iodide of potassium, and thus brought into immediate contact with the fungus in the hair-follicles.

### Syphilis.

In syphilis, we are fortunate in having several lectures from Mr. Jonathan Hutchinson. One is entitled "On Chancres and Syphilis, an elementary lecture addressed to students" (*Med. Times and Gazette*, March 21, 1885, p. 373, and March 28, p. 405). Although this is called elementary, it is full of interesting and instructive matter; as is also his lecture on "Herpes and the Recurrent Chancre, also on the Intermediate Period of Syphilis" (*Med. Press*, October 28, p. 391), but his

"Lettsomian Lectures on some moot Points in the Natural History of Syphilis, delivered before the Medical Society of London" early in the present year, may be considered as among the most suggestive and remarkable contributions which have appeared in recent times. It is not possible to abstract these lectures; they are reported in full in the *British Medical Journal*, January 9, 1886, p. 55, January 23, p. 141, February 6, p. 239, and February 13, p. 279, and will probably soon be republished in book form. Dr. Myrtle's "Clinical Remarks on Secondary Syphilis" (*Med. Press*, April 22, 1885, p. 343) give details of some interesting cases.

JOHN CAVAFY.

LONDON.

---

## Selections.

---

### INFLUENCE OF MERCURY IN DELAYING SYMPTOMS AND AS AN ANTIDOTE IN SYPHILIS.

MANY of the diseases just mentioned (rupia, psoriasis palmaris, syphilitic lupus, periostitis, symmetrical nerve affections) would probably occur much earlier in the evolution of constitutional syphilis, and would be recognized much more definitely as belonging to the secondary stage, were it not for the almost constant employment of antidotal specifics. The effect of mercury, when it does not absolutely cure, is usually to delay and retard. In many cases, the patient remains free from symptoms so long as he continues the drug, but experiences an outbreak within a few weeks or a few months after suspending its use. It seems to be quite easy, if mercury be begun on account of the primary sore, and well antecedent to the appearance of any secondary symptoms, to entirely prevent the development of the latter. I have witnessed this prevention over and over again, and it appears to be the rule, rather than the exception, that no secondaries should appear. The immunity, however, not unfrequently lasts only so long as the drug is continued, and within a few weeks after its omission, even when the course has been one of six or eight months, a rash on the skin will show itself. Thus it may easily be the fact that inflammations of the eye and ear, and of other parts of the nervous system, which occur, in the natural course of things, later than skin affections, may be yet further retarded by treatment, and may sometimes appear almost to encroach upon the tertiary period, although definitely belonging to the secondary.

#### *Influence of Mercury as an Antidote.*

Among the questions which may fairly be considered as moot points in the natural history of syphilis, we may count those which concern its relation to the specifics used in its treatment. The claim of mercury to rank as an antidote to the virus of syphilis, has, I think, been much strengthened by the results of recent experience, and it is one of extreme importance in reference to a very important department of general pathology and therapeutics. In connection with it, we may suitably bear in mind the great repute which weak solutions of corrosive sublimate have recently obtained in the prevention of septic processes in wounds. In former times, when mercury was given in large doses, and allowed to produce violent effects, and when, of necessity, its administration was frequently interrupted, the development of constitutional symptoms in some form or other was so constant, that much hesitation was felt by all as to the use of

such a word as "antidote." Of late years, we have got into the habit of using only small doses, and giving them over very long periods, carefully taking every precaution against the necessity for interrupting them. I will ask permission to state briefly my own rules of practice, and the impressions which I have formed as to results. As those impressions have been formed for many years chiefly in private practice, and amongst patients concerning whom I have often had opportunities for obtaining information over long periods, I am in a position to speak with much more confidence as to results than would otherwise have been the case. The remedy which I have used almost exclusively has been the gray powder, and the dose usually not more than a single grain. This dose I have given from three to six times in the course of twenty-four hours, according to circumstances, and seldom for a shorter course than six months in the first instance. If this dose be given to a patient with an indurated sore, but in whom, as yet, no secondary symptoms have appeared, the result will usually be that none will occur. If the rash have already made its appearance before the treatment is commenced, as a rule it quickly fades, and so long as the patient continues the remedy he remains free. The exceptions to completeness of freedom concern chiefly the mouth and the throat.

It is very seldom indeed that there is any difficulty in keeping the skin perfectly clear. In the tonsils, and sometimes in other parts of the lining membrane of the mouth, sores will occasionally form; and, although these are in a general way amenable to an increase of the dose, and to the local use of the drug (as a black-wash gargle), it is to be admitted that there do occur occasionally cases in which it is difficult to be sure that the supposed remedy does not aggravate the disease. In a large majority of cases, however, in which, beginning at an early period, the patient is put under a six months' course, during the last four of this period, he is absolutely without symptoms, and apparently in excellent health. If, however, at the end of this time, the remedy be stopped, in many cases a very remarkable proof of its antidotal efficacy will occur. We shall find that it was it, and it alone, which had held the poison in inactivity. For, in spite of the long period of absolute quiescence, an outbreak of symptoms will occur within a few weeks of its suspension. This outbreak is usually a very mild one, but is, nevertheless, very definite, and it is general. It usually takes the form of an erythematous or lichenoid eruption, occurring chiefly on the trunk, and is not often attended by sore-throat or other symptoms. Although it may now and then be papular, I have never seen it approach in severity the eruptions which we often see in cases which have not been treated. In more than one case, I have known this eruption which comes after the suspension of mercury mistaken for scarlatina. It is always, I believe, very easily amenable to mercury, disappearing in the course of a few days, or at most a week or two, and seldom recurring. There is, however, another very peculiar eruption which sometimes persists for a long time, and recurs over and over again. I have been in the habit of speaking of this as "after-bath eruption." It is a very trivial affair, and consists chiefly in the appearance of a number of faintly marked erythematous rings, which are seen only on sudden exposure of the body to cold, as on first getting out of bed, and especially after the use of the morning bath. Nine out of ten patients notice them only under the latter condition, and they generally fade away almost completely after a few hours. These rings are seen most frequently on the arms, but sometimes on the trunk and thighs. They are unquestionably syphilitic, and the liability to them usually ceases on the recurrence to mercurial treatment. They are seldom or never attended by other manifestations of the disease.



Respecting the results of treatment in general, I believe I may with truth assert that I have never, in any single case of late years, seen a severe eruption of the skin develop itself after a mercurial course of the kind indicated had been commenced. It is a fact, then, that the remedy manifests antidotal power in that it cannot only remove, but anticipate and prevent, by far the most conspicuous manifestations of the disease. I cannot make so strong an assertion respecting some other of the symptoms of the later part of the secondary stage. I have seen iritis and neuro-retinitis occur occasionally, with even some severity, in cases which had been well treated, and, in very exceptional instances, I have witnessed disease of the arteries of the brain. In a large majority of cases, however, a six months' course of small doses appears to be adequate to the complete and permanent cure of the disease. No relapses occur, and the patient remains afterwards in excellent health.

We may admit that it is a question which must be left open for future accumulations of evidence, whether the antidotal repression of the secondary stage is influential in preventing the development after a long interval of tertiary symptoms. That it does not do so always is abundantly proved. I cannot but believe, however, that it does exercise a very powerful influence in that direction, and that the diminishing frequency and severity of tertiary disease in modern times is largely due to better regulated treatment. It is often matter of remark that those who do suffer seriously after long intervals, are those in whom the early symptoms were exceptionally slight, and treatment in consequence not persevered with, or almost wholly omitted.

In urging the antidotal efficacy of mercury as a fact in the natural history of syphilis, I have not in the least wished to claim superiority for the special mode of administration which I have mentioned. I do not doubt in the least that the advocates of other methods, such as those by inunction or by the vapor-bath, can produce just as good results. The essential point seems to be that the treatment should be very long continued, or, if not, that short courses should be repeated without waiting for symptoms. The method which I have advocated is simply one of the most convenient.—Extract from a lecture by J. HUTCHINSON, *British Medical Journal*.

### EXCORIATIONES NARIUM.

In the *Monatschrift für Ohrenheilkunde*, etc., No. 7, 1885, there appears an article bearing the above title, and written by my friend Dr. Schmiegelow, of Copenhagen. Having recently had some cases of the troublesome affection which he describes under my care, in which the ulceration in the outer part of the nostril was progressing, and showed no sign of healing until treated with anti-bacterial agents, such as carbolic acid lotion, iodoform, etc., I think that the following conclusions which Dr. Schmiegelow has come to, and which I share, are of interest:

1. The term *Eczema narium*, which is sometimes applied to the affection, is misleading, because it only represents the less important and not constant accompaniment of the disease, which is really in the large majority of cases a furunculosis of the sebaceous glands which are connected with the vibrissæ in the nostril. Further, Moldenhauer concludes that the few cases in which there is no furunculosis, and where the affection is a pure eczema, are those of scrofulous children, or of adults where it is an extension of a facial eczema to the nostril.

2. Pasteur and Löwenburg have found a great many micrococci in the pus of a furuncle, and believe that the latter is caused by bacterial affection.

3. Every cause of solution of continuity of the epidermis may produce furuncle, by creating a nidus for the deposit and increase of micrococci, and through their agency inflammation of the sebaceous glands is set up. As chronic eczema of the external auditory meatus is the cause of furuncle in that situation, so eczema of the entrance to the nostril causes furuncle of the nasal cavity, since the patients thus affected, by removing the small scabs that form, produce solution of continuity of the epidermis, by rubbing the part in order to allay the irritation which is present, pull out small hairs, and thus allow of the possibility of micrococci getting into the sebaceous glands and inflaming them.

4. Individuals having numerous stiff vibrissæ in their nostrils are more predisposed to "excoriationes narium" than those who have a few short soft hairs, because the nasal secretion is not collected by the latter to so great an extent as by the former, and therefore scabs are not so readily produced.

5. The affection is most obstinate if it attack the region between the ala and septum nasi, as here there is more chance of stagnation of the nasal secretion, and more difficulty in removing the crusts that form.

6. The aims of treatment are:

1. To prevent the formation and increase of scabs.
2. To protect the epidermis from further solution of continuity.
3. To sterilize the nostril.

7. Epilation is irrational, as it only leads to the opening of new orifices hitherto closed by the hairs, into which micrococci find their way, and by multiplying form abscesses. Baumgarten also denounces this method of treatment. Also the old-fashioned treatment, by means of ointments, glycerin inunctions, and application of nitrate of silver, are all untrustworthy, if not worse.

8. The treatment to be recommended is the following: Small pieces of cotton wool are soaked in an aqueous solution of corrosive sublimate of the strength of 1 to 1,000, or, if this is irritating, of 1 to 2,000. The tampons must be of such a size as to quite fill the nostril, and one nostril at a time is to be filled with its tampon, which must be allowed to remain in it for two hours, then removed, and the other, if affected, operated on. This must be done two or three times daily at first; later on, one tampon a day for each nostril may be sufficient. If irritation is set up by the  $\text{HgCl}_2$  it should be omitted for a few days, and an ointment, composed of one part of boracic acid to 10 of vaseline, used instead; the use of  $\text{HgCl}_2$  being resumed when the irritability is allayed. Treated in this way, no new crusts form, the patients do not "pick their noses" and thus increase the area of infection, and the part acted on is sterilized.

9. This treatment has proved most successful in more than forty cases, the cure being absolute in nearly all in the course of a fortnight. If the affection shows any tendency to recur, washing with the weaker solution of  $\text{HgCl}_2$  is sufficient to prevent it.

10. Where scrofulous children are affected with nasal excoriation, which is often of doubtfully parasitic origin, Kisselbach recommends the application of tampons which are soaked in a diachylon and petroleum ointment, as the use of  $\text{HgCl}_2$  for these patients is usually too irritating.

Dr. Schmiegelow has given up the use of the stick of nitrate of silver for these nasal ulcers, and so have I. I may add that in syphilitic and tubercular ulcers of the tongue I have found that the use of a saturated solution of iodoform in ether is very valuable. Numerous cases under my care in which these ulcers had been treated for months by solid caustic, with no effect excepting irritation of the part, yielded to the iodoform treatment, the healing process beginning very soon,

and the patients complaining of much less pain after its use. I tell the patients to rinse the mouth with cold water after each meal, and then paint on or spray on to the ulcer some of the iodoform solution, when the iodoform is left in very fine powder on the ulcerated surface.—DR. BARON, *Bristol Medico-Chirurgical Journal*, March, 1886.

### CHRYSOPHANIC CONJUNCTIVITIS.

THAT the application of chrysophanic acid to the integument is sometimes followed by a disagreeable conjunctivitis has long been recognized as constituting one of the chief objections to its use. This objectionable result was most frequently observed after its application in the form of an ointment to the integument of the head and face, and was supposed to be due to an irritant action from direct contact. It was sought to be corrected by the substitution of pyrogallic acid or the oil of cade in the treatment of psoriasis affecting these regions. The general use of the chrysophanic acid in the form of fixed adhesive dressings, in combination with collodion, gelatin, or traumaticine, was also thought to have diminished the danger of its occurrence.

Dr. Trousseau (*Annales de Dermatol. et de Syphilig.*, May 25, 1886) has made a special study of chrysophanic conjunctivitis. According to this authority, it occurs in from four to fifty per cent of all patients treated with the traumaticine combination. He also asserts that the application of chrysarobin to the trunk and lower extremities is just as likely to provoke a conjunctivitis as when applied directly to the face.

The clinical features of chrysophanic conjunctivitis are thus described. During the night following the painting with the traumaticine, the patient is awakened with a sharp, smarting pain in one eye; there is a pricking sensation as if sand were in the eye. The next day, the pain is markedly increased; there exists blepharospasm and intense lachrymation, sometimes a slight degree of photophobia; the conjunctiva is injected, but there is no trace of conjunctival secretion and the cornea is normal. This affection then makes its debut brusquely, as a rule from twelve to twenty-four hours after the application; it is almost always double, one eye is affected, and some hours later the other eye becomes inflamed. In one case, three days elapsed before the second eye became affected. When the affection is established, besides the symptoms of pain and irritation just mentioned, the bulbar conjunctiva becomes quite red and vascular; the palpebral conjunctiva presents the same aspect, especially the inferior palpebral conjunctiva. It sometimes happens that the superior palpebral participates but slightly in the inflammatory process; in this case it was not involved.

The duration of the acute stage is three or four days; the pain, the lachrymation, and the blepharospasm begin to subside on the third day; the injection persists longer, especially over the globe and in the inferior cul-de-sac. All the phenomena disappear at the end of eight or ten days without treatment. The symptoms may be alleviated and the duration of the disease abridged by the continuous application of compresses dipped in lukewarm borated water (four per cent). The fact is insisted upon that there is an absence of conjunctival secretion; sometimes the eyelids may be glued together upon awakening in the morning.

The author devotes some interesting study to the question whether the conjunctivitis is due to a direct inoculation of the chrysophanic acid by the intermediary of the fingers, or whether it is a manifestation of a general intoxication

by the acid, consecutive to its absorption by the cutaneous surface. He made some experiments upon the eyes of rabbits, introducing a small quantity of the solution. In all of the twelve rabbits experimented upon, there was provoked a muco-purulent or frankly purulent secretion. The patients who touched their eyes with their fingers soiled with the chrysophanic solution presented a conjunctivitis with secretion.

He concludes that chrysophanic conjunctivitis, characterized by dryness or absence of secretion, is due to absorption of the medicament, and not to direct contact, at the same time admitting that more complete studies are necessary before the question can be regarded as definitely settled.

### TREATMENT OF PIGMENT SPOTS OF THE SKIN.

ACCORDING to Unna, borax and the bichloride of mercury are the medicaments must generally employed for the removal of pigment spots; the first is slow and mild in its action, rarely occasioning eczema; the second acts more energetically and rapidly.

If we desire to have the speediest possible effect, it is necessary to have recourse to mercury, not in the form prescribed by Hebra, which is inconvenient, but a solution of the sublimate in collodion (one-half to one part). The danger will thus be avoided of provoking redness, desquamation, and sometimes even a bullous eruption.

These energetic treatments have one inconvenience: we cannot exactly measure the effect. On this account, it is preferable to employ the mercury and bismuth ointment proposed by Hebra. A piece of muslin coated with the ointment will enable us to obtain a more prompt effect than with feeble solutions, besides being much more convenient of application.

Small pieces of muslin, about the dimensions of the groups of freckles or chloasmic spots, should be smeared with the ointment, and after first removing the greasy matter from the surface with cologne or alcohol, they should be applied to the affected parts. The application should be made upon the patient's retiring at night, and washed off the next morning. Bandaging or collodion is unnecessary.

The author prescribes for use during the day a bismuth ointment, which has the advantage of masking the brown spots.

The following is the formula of the ointment:

℞ Oxide of Bismuth,		
Kaolin. ....	ãã	5 grams.
Vaseline.....	20-40	“

M.

The ointment should be applied only to the pigmented spots, allowed to dry and not be removed for some time.

He also employs the following formula:

℞ Oxide of Bismuth,		
Rice Powder.....	ãã	2 grams.
Ung. Glycerinæ.....	10	“
Eau de Rose.....	20	gutt.

M.

By alternating the mercurial and bismuth applications, the pigment patches rapidly disappear without redness or desquamation, if the pigment be not so



deeply situated in the derma that the remedies cannot reach it without destroying the papillary layer, as is the case in certain chronic chloasmas.

The following is Hebra's formula:

℞ Subnitrate of Bismuth,	
White Precipitate.....	āā 2 gr. 50
Lard.....	50 grains.

M.

To be spread upon a piece of lint, and applied during the night to the pigmented patch.

Kaposi employs the following ointment in the same manner.

℞ Salicylic Acid.....	2 grams.
Emcillent Ointment.....	40 “

M.

Or,

℞ Boracic Acid,	
White Wax.....	āā 5 grams.
Paraffin .....	10 “
Oil of Almonds.....	30 “

M.

Frictions with the ordinary mercurial ointment sometimes succeed well.—

*Jour. de Méd. de Paris*, No. XV., 1886.

### ERUPTION OF HERPES ZOSTER DURING THE EMPLOYMENT OF ARSENIC.

IN connection with a few cases of zoster appearing after the prolonged use of arsenic, which were already known to the profession, Dr. Julius Burger (*Vierteljahrschr. f. Dermat. und Syphilis*) reports three new instances in which, after several months' use of arsenic, typical unilateral zoster appeared along the course of the intercostal nerves.

In spite of a continuation of the arsenic, no relapse occurred after the healing of the first eruption. The author is not fully convinced of the dependence of the zoster upon the arsenic. It is not plainly to be seen how a single nerve should be altered by the arsenic. Again, in his cases, all symptoms and appearances of arsenical poisoning were absent, and finally the absence of recurrence of the disease in spite of a continued use of the drug led the author to believe in an accidental coincidence.—*Wiener Med. Wochensch.*, No. 9, 1886.

### ANÆSTHESIA OF THE SKIN FROM MERCURIAL POISONING.

HYPÆSTHESIA of the skin as a result of mercurial poisoning has been recognized as the effect of the drug upon the sensory nervous system.

Freney has recently reported a case in the *Gazette des Hôpitaux* in which the very opposite effect was noted, viz.: anæsthesia. A workman in a mirror factory, presenting all the symptoms of mercurial poisoning, showed anæsthesia of the whole body, which was more marked on the right side. Thermal sensibility was suspended also on this side and in both lower extremities. Analgesia was observed in regions where tactile and thermal sensibility was not entirely abolished.

After the use of iodide of potassium and sulphur baths, these symptoms entirely disappeared.

## Editorial.

---

### ARSENIC IN SKIN DISEASES.

THE claim that arsenic is the most valuable remedy we possess in the treatment of diseases of the skin has been so long accepted as an established therapeutical fact, that any question of its superior efficacy may appear like downright heresy. Arsenic is not only reputed to possess specific virtues in certain forms of skin affection, but it has been accredited with a wide range of therapeutic action, and has been recommended in so many diseases which have no etiological or pathological relationship, that it has come to be considered by many as a sort of panacea for all cutaneous disorders. Certainly no other drug has been so universally employed, and in so large a variety of morbid conditions of the skin.

Whether the reputation of arsenic as a remedy in skin diseases rests upon a basis of sufficiently careful clinical experience is a proper subject for inquiry.

The universality of its employment cannot be accepted as affording positive proof of its therapeutic worth. The history of medicine records many drugs which, after enjoying a more or less extended reign of professional favor, have been relegated to the limbo of forgotten or disused remedies. We do not wish to be understood as intimating that a similar experience is likely to befall the drug now under consideration, but we think it exceedingly improbable that it will always continue to hold the high place it has occupied in cutaneous therapeutics. For a number of years we have regarded arsenic as a very much overrated drug, and while we recognize its undoubted efficacy in a limited number of chronic inflammatory disorders, we believe that the range of its judicious application is comparatively restricted.

We are glad to find ourselves so nearly in accord with the views embodied in Dr. Fox's propositions, published in the last number of this JOURNAL, respecting the value of arsenic in skin diseases. Especially would we join in his protest against the "practice of giving arsenic in nearly every case of skin disease as irrational and harmful." A full and free discussion of these important propositions cannot fail to be of the

greatest practical interest, both to the specialist and the general practitioner.

We had hoped to present in this number the views of the members of the New York Dermatological Society upon these points, but, unfortunately, the discussion was postponed until a future meeting. While the majority of physicians will probably not yield unqualified approval to Dr. Fox's somewhat sweeping denunciation of arsenic, yet we think all will agree that its routine administration in cases where there are no rational indications for its use is to be condemned.

That arsenic, perhaps more than any other drug, exercises a positive and direct influence upon the nutrition of the skin cannot be questioned. There is scarcely any form of eruptive disturbance which may not be provoked by its internal use. A reference to the article on "Arsenical Eruptions" in the present number shows how wide is the range of its pathogenetic influence.

The fact that arsenic is capable of producing such a marked and decided impression upon the skin has been held as an argument for its efficacy as a remedy in diseases of this organ, on the principle that the more powerful the poison the more potent the remedy. This principle cannot, however, be accepted as a safe guide in determining the therapeutical value of the drugs employed in dermatological practice. Bromide of potassium, for example, produces eruptive disorders of the most severe and varied character, yet it does not play an important rôle in cutaneous therapeutics. The dermatopathic influence of iodide of potassium is as pronounced, perhaps, as that of arsenic, yet its value is recognized in only a single class of eruptions. The same may be said of quinine and many other drugs capable of causing a morbid determination toward the cutaneous surface. The study of the physiological and toxic effects of a drug does not always afford correct indications as to its remedial action. Upon this point conclusions of practical value can be gained only by careful and extended clinical observation.

With the view of collecting and comparing the results of the experience of a large number of physicians, we would request each of our readers to furnish us information upon the following points :

Are you in the habit of employing arsenic, *generally*, in the treatment of diseases of the skin ?

In what forms of skin disease have you found arsenic of superior value to other remedies?

What ill effects, if any, have you observed from its use?

What preparation of arsenic do you prefer, and in what doses do you employ it?      Address:

EDITOR OF JOURNAL OF CUTANEOUS AND VENEREAL DISEASES,  
66 West 40th street, New York.

---

## Reviews.

---

LEHRBUCH DER HAUT- UND GESCHLECHTS-KRANKHEITEN, für Studirende und Aerzte. Von DR. EDMUND LESSER. Zweiter Theil. Geschlechts-Krankheiten. Leipzig: Verlag von F. C. W. Vogel, 1886.

The first part of this work, relating to diseases of the skin, was favorably noticed in a previous number of this JOURNAL. The second part is devoted exclusively to the consideration of venereal diseases. It may be a question whether skin and venereal diseases are sufficiently related to justify their forming component parts of the same treatise. Certainly, from a general standpoint, the group of affections, comprehended under the general term venereal diseases, is entirely distinct, but since the principal phenomena of the most important member of this group—syphilis—are manifested upon the skin, its nosological position has naturally been placed among diseases of the skin. From a clinical point of view, however, the separation of dermato-syphilis from the ordinary dermatoses is not practicable, as they are constantly brought into close association for purposes of differential diagnosis.

As in the preceding volume, the author aims to give a clear and concise exposition of our knowledge of the subject, sufficiently comprehensive to embrace all essential points, without being too diffuse or exhaustive for the wants of the student. His description of the different diseases, their symptoms, complications, and treatment is to be commended for its simplicity, accuracy, and brevity. The author accepts as an established fact the bacterian origin and nature of venereal diseases. He recognizes the gonococcus of gonorrhœa and the bacillus of syphilis as the sole pathogenetic factors in the causation of these diseases; the microbial origin of chancroid he regards as in the highest degree probable, though not definitely proven.

Although he is a firm believer in the parasitic origin of gonorrhœa, we do not perceive that anti-parasitic treatment figures prominently in his means of cure. His assertion that non-specific urethritis is distinguished by its short duration and spontaneous cessation is open to question. On the contrary, it is often found that a urethritis, dependent upon other causes than contagion, may be characterized by prolonged persistence and obstinacy to treatment.

In the treatment of primary syphilis, the author strongly recommends the excision of the chancre as an abortive measure. He says, "the primary affection is in all cases to be excised, when its localization admits of the operation, and when too long a time has not elapsed since infection." In the general treatment of syphilis he regards mercurial inunctions as the most promptly efficacious of all



methods of employing the drug. He describes in detail the technique of subcutaneous injections, and reviews the list of mercurial preparations which have been recommended for this purpose. Due consideration is also given to the local treatment of syphilitic lesions.

DE LA SARCOMATOSE CUTANÉE. Par Le Docteur LEON PERRIN, Ancien Interne en Médecine et en Chirurgie des Hôpitaux de Paris. Paris: G. Steinheil, Editeur, 1886.

This monograph of nearly 300 pages, which forms the inaugural thesis of Dr. Perrin, must be regarded as a most valuable contribution to medical science.

The tumors of the skin embraced under the general term "sarcoma," though comparatively rare, are of great clinical importance, yet they are mentioned only in the more recent text-books on dermatology and, indeed, their very existence as a distinct class of neoplasms was not recognized until a few years ago.

The literature of cutaneous sarcomata has been embodied principally in observations scattered here and there in medical journals. The cases have been reported under a great diversity of titles, the observers themselves often being ignorant of the name and nature of the disease described. It is not surprising, therefore, that our knowledge of this important class of affections should be so vague and unsatisfactory. Dr. Perrin has attempted the difficult task of evolving order out of confusion by analyzing this mass of crude material, and reducing it to the proportions of scientific knowledge. His work is based upon the careful study of fifty-four cases of cutaneous sarcomata which he has found recorded, together with two cases which came under his personal observation during his internat at the St. Louis Hospital. These cases he has classified and arranged according to their histological and clinical characters and has given us a clear and intelligible description of the different varieties of sarcoma, with their typical and differential features. Some of these cases were not found to correspond with any of the recognized types of sarcoma and, in constructing his classification, he has traced new types of the disease.

The first chapter is devoted to an exposition of the views of different authorities as to the nature of sarcoma. He accepts the definition of Cornil and Ranvier, viz.: "Tumors constituted by pure embryonic tissue or undergoing one of the first modifications in its transformation into adult tissue."

Sarcomata of the skin are divided into two principal classes: 1st, *Melanotic* sarcomata; 2d, *Non-melanotic* sarcomata; the first constituting a group perfectly distinct, the second being subdivided into *primitive idiopathic* and *secondary metastatic*. The primitive idiopathic sarcomata may be either generalized or localized.

The mode of debut, the evolution, the objective characters, and the pathological anatomy of these different varieties are then considered in detail, together with their etiology, prognosis, and treatment. The lines of demarcation which separate true sarcomata from other cutaneous lesions presenting similar objective and clinical characters are clearly indicated.

A very interesting study is made of the relation existing between mycosis fungoide and generalized sarcomata—two diseases which are regarded by many authorities as identical. Our author believes in the distinct individuality of mycosis fungoide, while admitting that the mycosis group includes a variety of sarcoma which he denominates "primitive generalized sarcoma of a pseudo-mycotic form."

It is, of course, impossible, without entering into an extended analysis of the

work, to give more than an outline of its general character and scope. We cannot too highly commend the scientific spirit displayed in undertaking this difficult task, the painstaking labor expended in collecting and systematizing such a mass of material, and the intelligent judgment exercised in dealing with the difficult and obscure questions with which it is surrounded.

The work is enriched with an admirably executed chromo-lithograph, representing the histological characters of a generalized primitive non-melanotic sarcoma which the author personally studied.

**THE PRINCIPLES AND PRACTICE OF MEDICINE.** By the late CHARLES HILTON FAGGE, M.D., F.R.C.P., Physician to and Lecturer on Pathology at Guy's Hospital, etc. Including : A Section on Cutaneous Diseases, by P. H. PYE-SMITH, M.D., F.R.C.P. Chapters on Cardiac Diseases, by SAMUEL WILKES, M.D., F.R.S. And Complete Indexes, by ROBERT EDMUND CARRINGTON, M.D. In Two Volumes. Philadelphia : P. Blakiston, Son & Co., 1886.

In the preparation of this Treatise on the Practice of Medicine, its late lamented author, we are informed, was constantly occupied the last twelve years of his life. It embodies the results of his laborious researches as a pathologist, and of his observations and experience as a clinician during the long term of years in which he was connected with Guy's Hospital. His position afforded almost unexampled opportunities for pathological and clinical study, and the result shows that he utilized the rich resources at his command to the best advantage.

The first impression one has of this work is its magnitude, and the truly cyclopedic character of its contents. Nearly 2,000 pages of solidly printed matter, relating to every subject in the domain of practical medicine, and embracing certain special departments not usually treated in a text-book on practice, is certainly a phenomenal production, even in the present age of prolific writers.

Dr. Fagge was peculiarly fitted for successfully carrying out so great an undertaking. Naturally endowed with a wonderfully retentive memory, a zealous worker, with trained habits of observation, and gifted with sound judgment and a genius for the generalization of clinical facts, he has produced a work which has been justly characterized as "a fuller, more original, and more elaborate text-book on medicine than has yet appeared." Upon every page we have evidence of original thought and independent investigation. It is perhaps, more than any other systematic treatise on medicine, a personal one—the outcome of the author's individual observation and experience.

The first volume treats of General Morbid Processes, Specific Diseases, Diseases of the Nervous System, and Diseases of the Respiratory Organs. The second volume is devoted to Diseases of the Heart, Diseases of the Digestive Organs, Liver, Spleen, and Kidneys, Diseases of the Bones, Joints and Blood, and Diseases of the Skin; concluding with copious indexes of authors and subjects, which will be found invaluable in facilitating ready reference. As an evidence of the exhaustive manner in which the different subjects are treated, we may instance the fact that 444 pages are devoted to diseases of the nervous system alone, forming in itself a complete and elaborate text-book on this important branch.

The section on Diseases of the Skin is the work of the editor, Dr. Pye-Smith. While from the American dermatological standpoint exceptions may be taken to certain peculiarities of nomenclature and classification, yet in the description of

the different diseases, their pathology and treatment, and all essential points relating to a knowledge of the subject, his work is to be commended, and has been brought up to the latest advances made in this department.

This work may, with peculiar propriety, be recommended to the readers of this JOURNAL, a majority of whom are general practitioners, since, in addition to its high value as a standard text-book on the Principles and Practice of Medicine, it presents the additional attraction of including a complete treatise on Diseases of the Skin.

## Books and Pamphlets Received.

Die neueren Fortschritte in der Therapie der Hautkrankheiten, von P. G. UNNA, Hamburg. Reprint.

Die Bacillenklumpen der Leprahaut sind keine Zellen, von P. G. UNNA, Hamburg. Reprint.

Wo liegen die Leprabacillen? von P. G. UNNA, Hamburg. Reprint.

Erwiderung auf Unna's: Wo liegen die Leprabacillen? von DR. K. TOUTON. Reprint.

Zur Aetiologie der Alopecia Areata, von DR. MAX JOSEPH, Berlin. Reprint.

Die neueren Arbeiten über die spezifische Energie der Hautsinnesnerven, von DR. MAX JOSEPH, Berlin. Reprint.

Zur Casuistik des Lichen ruber planus der äusseren Haut und der Schleimhäute, von DR. A. J. PROPELOW. Reprint.

Storia di Idros-Adenite Neoplastica con relativo studio Theorico-clinico-anatomico, Altro Caso di Idros-adenite sifilitica. Pel PROF. CAV. PIETRO GAMBERINI.

Epididymitis Syphilitica. DR. KAROL SZADEK, Kieff, Russia. Reprint.

Lichen Planus Wilsonii. DR. K. SZADEK. Reprint.

## Items.

### ECZEMA OF THE HAIRY SCALP.—

℞ Acidi Salicylici.....	8 gr.
Spts. Mindereri.....	25 "
Glycerinæ.....	100 "

M.

—SCHWIMMER.

### SCABIES.—

℞ Naphthol,	
Chalk,	
Sulphur precip.....	āā 10 gr.
Lard.....	100 "

—SCHWIMMER.

EPIDIDYMITIS.—Painting with traumaticine.—SCHWIMMER.

**ANNUAL MEETING OF THE NEW YORK DERMATOLOGICAL SOCIETY.**—At the annual meeting, held May 25, 1886, the following officers were elected for the ensuing year:

President, Dr. R. W. Taylor.

Treasurer, Dr. E. B. Bronson.

Executive Committee, Drs. H. G. Piffard, E. L. Keyes, and P. A. Morrow.

According to the rules of the Society, Dr. Chas. W. Allen, the most recently elected member, becomes Secretary.

**CHANCRE OF THE CONJUNCTIVAL CUL-DE-SAC.**—Dr. Gillet de Grandmont reports the case of a Mine. B., æt. 26 years, who presented herself at his clinique with a conjunctivitis of the left eye, for which she had been treated during the past eight days. There was an intense injection of the conjunctival and episcleral tissues of the eye, the cornea was healthy, and the iris mobile. Upon depressing the lower lid, there was found in the conjunctival cul-de-sac, a little above the furrow, upon the globe, a large, red papule, elongated in the direction of the palpebral opening, and ulcerated at its summit, with grayish base. Its borders were elevated, and induration was evident; but as the mass could not be seized between the fingers, the characteristic sensation of an indurated chancre could not be obtained—a sensation which has been aptly compared to that of a button pressed beneath a fold of cloth. This papule seemed adherent to the sclerotic. An indurated gland in the parotid region confirmed the diagnosis of chancre.

Seven weeks later, there was an unmistakable papular eruption upon the face, neck, and arms, which rapidly yielded to subcutaneous injections of mercury.—*Journal de Médecine de Paris*, No. 12, 1886.

**TREATMENT OF GONORRHOÆAL HÆMATURIA.**—Dr. Horovitz recommends as the best treatment for hæmaturia following gonorrhœa, which usually has its origin in erosions or rhagades in the neighborhood of the neck of the bladder, or in the contiguous portions of the urethra, that a *canule à demeure* be inserted for twenty-four hours. If cystitis be present as well, the canule may be utilized to wash out the bladder.—*Centralblatt für Chirurg.*, No. 12, 1886.

**IODOL: A SUBSTITUTE FOR IODOFORM.**—Iodol is a new substance which bids fair to take the place of iodoform. It is a dark powder obtained from "Dippel's animal oil." It has but little smell. It is soluble in three parts of absolute alcohol, but only in five thousand parts of water. It has been extensively tried in Rome in the treatment of chancres, buboes, etc., and very good results have been obtained. It has proved equally valuable in many cases of simple indolent ulcer.—*London Record*, Feb., 1886.

**CHLORIDE OF CALCIUM IN SCROFULOUS AFFECTIONS.**—Dr. Coghill's formula for scrofulous affections is to dissolve  $\frac{3}{4}$  v. of the crystallized salt of chloride of calcium in  $\frac{3}{4}$  xij. of syrup. Of this he gives  $\mathfrak{v}$ . to  $\mathfrak{x}$ l., according to age, in milk after meals.—*Exchange*.

**A NEW DEODORIZER.**—According to the *Birmingham Medical Review*, a saturated solution of sodium hyposulphite mixed with an equal quantity of water destroys the fetor of cancerous ulcers.

**PERSONAL.**—Dr. Chas. W. Allen, of this city, proposes to spend the summer at Richfield Springs, and study the effects of sulphur water in diseases of the skin.



# JOURNAL

OF

## CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

AUGUST, 1886.

No. 8.

---

### Original Communications.

---

#### FOUR CASES OF LATE SYPHILITIC LESIONS OF THE RECTUM.

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

THE past few years have witnessed a marked change in the views of the medical world as to the relations of syphilis to stricture of the rectum. To-day it is quite generally conceded, that syphilis is frequently the cause of rectal stenosis, and although the etiological relation between that diathesis and the annular fibrous variety of stricture is not clearly and sharply made out, its occurrence in syphilitic subjects is by many admitted as being caused directly by syphilis, and not, as it has been claimed by some, a simple coincidence. Study and observation, extending over many years, in an extensive field, have convinced me that, as an etiological factor in affections of the rectum, syphilis plays a much greater part than it is now generally thought to do. Not only in its late stages is the rectum quite frequently affected by it, but also in its earlier periods it is prone, under certain circumstances, to involve that organ. In the present communication, I desire to place on record four cases of late syphilitic affection of the rectum. Of these cases, three were under my care, and the fourth was seen in the practice of a medical friend. I may here state that the present cases are not the only ones I have observed of late syphilitic rectal lesions, but that they are the only ones of which I have kept quite full records. Others occurring in hospital and dispensary practice were observed sometimes in haste, and

always with irregularity on the part of the patients, so that it was impossible to obtain a satisfactory history. In a later paper I propose to consider the relations of syphilis to stricture of the rectum in all its forms.

CASE I.—In June, 1878, S. C., a young man aged 28, of rather poor fibre, of light complexion, and very pale, came to me with an indurated chancre of the prepuce and glans. He had never been very strong, and his careless habits of life, and tendency to drink, had militated much against his health. His business called him to various parts of the country, and I am convinced that the rather severe course which syphilis ran in his case was due to his weakly constitution, to his irregular life, his addiction to alcoholies, and his failure to follow out the treatment ordered for him. In the early part of August of this year, he suffered from a generalized small miliary papular syphilide, which showed a tendency to become slightly pustular. Later on, he had iritis, severe cephalalgia, and persistent redness of pharynx, with mucous papules on tonsils and sides of tongue. During this period he was submitted to a mercurial and tonic treatment, which he underwent in, for him, a tolerably methodical manner. Absent from New York for nearly two years, during which he had taken no medicine worthy of mention, he returned in the fall of 1880, suffering from gummos infiltration into the soft palate and posterior wall of the pharynx. This condition was seemingly cured by Christmas, and the patient was, according to his story, free from any traces of syphilis, until the summer of the year 1882, when he had a relapse of the infiltration in the posterior pharyngeal wall. This was, as before, treated locally and internally with a mercurial and iodide of potassium mixture, with the result of a cure in about two months, at which time no redness of the pharynx was noted. There were, however, two atrophic spots, one above the other, extending up behind the soft palate, and seated on the posterior wall of the pharynx.

I did not see the patient again until the winter of 1883, and then learned that he had discontinued treatment for more than a year, had led a dissolute life, had had, while in Cincinnati, what was called inflammation of the brain, which he laconically remarked was a combination of whiskey and sunstroke, and perhaps a little syphilis. At this time I found him very thin, weakly, with little appetite, and suffering from a rectal affection. He said that during the summer, while in the far West, he had suffered from a severe but subacute diarrhœa, which lasted fully two months, and was attributed to the impurity of the water of the place at which he was stopping. Other persons, he informed me, had suffered in the same way. He said that after the cessation of the diarrhœa he suffered much from constipation, so that he was forced to resort to strong cathartics, and often to use, in addition, laxative enemata. During this period, including the months of September to December, he

began to feel an uneasy sensation in the rectum, and particularly at the anus, while at stool, and at various times during the day. He noticed that occasionally he had a gluey discharge, sometimes tinged with a small amount of blood. Just before his visit to me at this time he had a quite marked hemorrhage, in which he thought he lost a tablespoonful of blood. He was convinced that he had internal piles. Examination showed no trouble with the sphincteric portion of the rectum, but just about its junction with the ampullary portion, a distance of nearly two inches on the posterior and left wall of the rectum, was a distinctly thickened portion of mucous membrane, about one and a half inches long, by nearly two in width, having sharp, abrupt margins. It was raised fully one-third of an inch, and its surface was firmer, less elastic than the rest of the rectum, and presented the sensation of a warty, somewhat papillomatous growth to the touch. No pain was caused by careful digital exploration, nor by the speculum. To the eye, the patch or tumor was of a deep-red color, and numerous prominences, seemingly seated around the follicles, were scattered over the surface. At its inferior border, at about the middle of the swelling, was a fissure fully half an inch long, and seemingly about a quarter of an inch deep when the membrane was in its natural, unstretched condition. This fissure was the seat of slight ulceration. A small quantity of sanguinolent muco-pus ran down from the lesion. Knowing the history of the patient, I diagnosticated the case as one of gummatous infiltration of the rectal wall. The mixed treatment was prescribed internally, together with such agents and means as would improve nutrition. Locally he used every night, after irrigation of the rectum with a warm alkaline fluid, a suppository containing at first five grains of mercurial ointment, and later on, ten grains, in combination with a small amount of opium. I had much difficulty with the fissure, which underwent ulceration, but which was finally healed up by using during the day suppositories of iodoform. Care was taken that a soft movement of the bowels occurred every day.

After four months of such treatment, the swelling was nearly all dissipated, and a hardened and condensed condition of the mucous membrane was left. The patient then disappeared until late in the summer of 1885, not quite two years from the date of invasion of the rectal lesion. At that time I found a well-defined puckering of the membrane, resulting from a firm cicatrix, which was rather more than an inch long and not quite an inch in width. I have not seen this patient since, though I learned recently that he said he was quite well. I may add that I have seen an infiltration in the posterior and lateral walls of the vagina of a syphilitic woman 34 years old, which, though not as salient as the lesion in this case, was rather greater in surface.

CASE II.—Early in 1884 I was consulted by a lady 40 years of age,

from a neighboring town, who eight years before had been infected with syphilis by her husband. In the first two years of her disease she, as well as her husband, was ignorant of the fact that she was syphilitic, and it was only after much questioning on my part and efforts at recollection on hers, that she called to mind that she had had slight fall of hair, sore throat, and a mild rash. Her physician assured her husband, as I learned from him, that she had a mild, but rather chronic attack of diphtheria. During the first three years of her syphilis she aborted twice at seven and eight months respectively. In the winter of 1883, she noticed two swellings at the internal ends of each collar bone, which increased quite rapidly, and in February, 1884, each swelling opened and gave vent to a thin, gummy, purulent fluid. At about the same time she noticed that there was something wrong with her vagina, and that at defecation she experienced a sensation of hindrance of expulsion as she termed it, she did not seem to have the power she formerly had. She also noticed that when using a vaginal enema that the posterior wall was not as supple as formerly. She complained of no pain, but had noticed at times a small quantity of viscid mucus in her stools, particularly when constipated. She was a rather fat and flabby woman, with dark-brown hair, and a sallow complexion. She was not particularly weak, had a good appetite, and was cheerful in disposition. Upon examination, over each sternoclavicular articulation a well-marked gummatous ulcer of nearly the size of half a dollar, the base of which was formed by necrotic bony tissues. The anus was normal, but rather more than two inches above, on the anterior wall of the rectum, was a hard, firm patch or tumor of oval shape, of a diameter of fully two inches. It was elevated fully half an inch and had a convex, slightly papillated surface. There was slight tenderness in and around the tumor, but no abnormal heat nor discharge. On examination of the swelling bimanually, with the fingers in rectum and vagina, it was found to involve the mucous membrane of the rectum, and seemingly to encroach on the subcutaneous tissue between that and the vagina. Its shape was readily made out and found to be distinctly movable. The same course was pursued as in Case I., with good results. I examined this patient in February of this year, 1886, and could only find a slight contraction of the mucous membrane of the rectum, not enough, however, to produce the slightest obstructive symptom. The patient had then followed treatment for more than a year and was in excellent health. She informed me that she had not been as well in fully ten years as she was then.

CASE III.—In the summer of 1878, Mrs. O'C., Irish, 28 years old, married ten years, and the mother of two children, came under my care at the Bellevue Out-door Department. She was a very large, fleshy woman. She had had syphilitic manifestation for four years, having



been infected by her husband. She had nodes over the whole cranium and gummatous ulcers on the buttocks and legs. Though she was not as attentive as she should have been to treatment, the nodes had disappeared, and the ulcers were healed in November of that year. I saw little of the patient again until March, 1880, when she came complaining of what she called piles. She said that three months before she had given birth to a child at eight months, and that during her pregnancy and since she had suffered much from constipation, and latterly had felt much uneasiness in her rectum, from which there was a foul discharge. On examination, I found the anus red and inflamed, and on introduction of the finger two inches into the rectum, on its posterior and lateral wall was a deep ulcer with thickened and sharply cut edges, and of an area of fully two inches. A profuse, bloody, purulent discharge escaped. The woman at this time was much debilitated, and suffered from alternating diarrhoea and obstinate constipation. She was placed upon the mixed treatment, laxative cathartics were administered, and suppositories of iodoform and belladonna were inserted into the rectum after the use of warm alkaline enemata. I had much difficulty with this case at first, owing to the persistency of the ulceration. Later on, according to my directions, her husband, who was a practical mechanic, made an appropriate speculum of wire on the plan of that devised by Pinkham. By means of this I taught him to insufflate the ulcer with equal parts of subnitrate of bismuth and iodoform. The result was a cure in about two months. I hunted this patient up recently, and examined the rectum and only found a cicatricial ridge with no appreciable stenosis of the gut.

CASE IV.—The next case I saw in consultation with my friend, Dr. C. E. Lockwood, who kindly furnished me the following history:

K. W., female, aged 23, syphilitic five years, was first seen in May, 1885. She desired treatment for what she called an abscess. On examination, on the posterior wall of the vagina, about two and a half inches deep, was a ragged opening through which a probe could be passed into the rectum, and withdrawn through the anus; there was also a stricture of the rectum about two and a half inches up. The woman stated that she had discovered a lump in the posterior wall of the vagina about two months before, which was not accompanied with pain. She had for several months previously suffered from the local effects of the stricture of the rectum.

The case when seen by me presented a well-marked rectal stricture, just admitting the end of the index finger, and an opening the size of a quarter of a dollar, with ragged coppery-colored edges, which was much larger in the rectum than in the vagina, showing that the morbid process invaded the rectum first, and later on the vagina. The opening was just

below the lower edge of the stricture. The latter was of the typical annular fibrous variety. The woman was placed upon a tonic and anti-syphilitic treatment, with local medication, by which the ulcerating opening was closed in about four months. The treatment of the stricture was deferred to a later date.

40 WEST 21ST STREET.

---

## THE USEFUL ADMINISTRATION OF ARSENIC IN DISEASES OF THE SKIN.

BY

EDWARD L. KEYES, M.D.,

Professor of Syphilology and Dermatology, Bellevue Hospital Medical College.

THE short article which appeared in the first number of the *New York Medical Mon'ly*, from the able pen of Dr. Fox, upon "The useless administration of arsenic in diseases of the skin," seems to me to call for a word of protest from some one who thinks better of this drug than Dr. Fox appears to do, and especially so since the editor of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, in the *Medical Record* of June 26, has made a general call for expressions of opinion upon this important subject.

The words of Dr. Fox and his argument, as he puts it, can hardly be controverted, but the implications of his article, and the generalizations which are sure to be drawn from it, seem to me to be damaging in their tendency, and likely to be effective of more harm than good; and therefore, since it is a very poor question which has not two sides, I wish to say a word on the other, and what seems to me to be the better side.

The general practitioner who has his routine prescription for all known symptoms, and who, upon seeing a malady of the skin, takes his pen and orders five-minim doses of Fowler's solution three times day, in the vague conviction that by so doing he has performed his whole duty to his patient, is undoubtedly condemned by this simple act, and all that need be said of him or to him is that he ought not to treat skin diseases at all.

The value of diet, of hygienic measures, of topical applications; the study of diathesis, and the just appreciation of the cause of a given skin disease—all of these are doubtless more valuable factors of treatment than the administration of any drug, and a physician is hardly worthy of the name if he relies upon medicines alone in the management of any malady—cutaneous or general. In so far, therefore, it appears to me that the generalizations of Dr. Fox are accurate; but beyond this they appear

faulty, because they seem by implication to attempt to weaken general confidence in a remedy which, carefully used, holds a very high, if not the first place in cutaneous general therapeutics, notably in the management of chronic disease.

The same rebuke (*i. e.*, routine administration) may, with equal justice, be cast at cod-liver oil and the hypophosphites as to their applicability to phthisical maladies, at colchicum, at quinine, at mercury, at iodide of potassium, or at any other drug. One man may use any of these remedies without effect against a malady over which they are well known to exercise a more or less controlling influence, and he may fail; while another practitioner, continuing the same remedy and intelligently supplementing it by other means, may conduct his patient safely to a cure.

I am not in a position to champion arsenic or any other remedy as a general "skin-success," but if there is any other drug more far-reaching in its influence for good upon the skin in a general way I have yet to learn it, and Dr. Fox has not suggested what it is.

My observation and experience in relation to the use of arsenic allow me to generalize only upon a few points.

Arsenic is distinctly a cutaneous stimulant; therefore, in the initial stage of a malady possessing an inflammatory element (notably eczema), it is not only not useful, but may be actually pernicious. Used after the acute stage has been controlled by appropriate means, it often speeds the parting guest and prevents it from lingering in a state of prolonged and desperate chronicity. A fitting analogy is the use of friction and massage in joint disease. This remedy is very efficient, but it has its time and place. When the joint is acutely inflamed, massage only adds fuel to the flame; but when the fire has been subdued, then the stiffness and loss of motion, perhaps otherwise inevitable, may be often overcome by the skilled application of massage. If the joint would get well without the massage, there is no call for its use, and no one but a routinist would employ it, yet that it has its use can hardly be denied, and so with arsenic.

Arsenic, in my opinion, is not useful unless the stomach tolerates it well and appropriates it in a kindly way. When digestion is interfered with by the use of arsenic, nausea or inappetence produced, it generally does no good, often harm. In such instances, preparing the stomach beforehand, changing the diet, disgorging the liver, giving attention to the patient's personal habits will allow the remedy to exert an influence, where unaided it would be without value or even harmful. The same remarks apply exactly to the administration of cod-liver oil, and often to the use of iron and other tonics.

The different preparations of arsenic may be called into play here in

selected cases. I have more than once taken a patient with chronic psoriasis, who had hopelessly given up the use of Fowler's solution because it troubled his eyes, ruined his digestion, and seemed to irritate his skin, and conducted him to a cure by combining arsenious acid with nux vomica and pepsin, with some changes in diet, or by substituting the arsenite of soda for the arsenite of potash. The Bourbonle water, a mild solution of the arsenite of soda, is a very gentle way of administering arsenic; too gentle as a rule, but yet I believe often effective of good, particularly in the case of weak digestion. Fowler's solution, especially if it has been long prepared, is very likely to disagree with digestion, and for this reason I seldom use it.

The more diffused, generalized, and chronic that a given cutaneous malady is, the greater do I consider the indication for the use of a suitable preparation of arsenic, if the stomach will take it kindly. The more localized an affection is, be it ever so chronic, the less indication is there for arsenic in a general way, in my opinion.

Generalized chronic eczema, generalized psoriasis, and pemphigus may, perhaps, be selected as the maladies in which arsenic may be expected to exert what may be termed a certain specific general effect in controlling the symptoms—exceptions to the contrary notwithstanding. Yet the combination of mild doses of arsenic with other remedies is not without value in some localized maladies, and in combating some forms of acne and some cutaneous manifestations of syphilis. Much also might be said, but more cautiously, in the case of neurotic maladies as affecting the skin, and where an element of nervous debility keeps down the patient's general vitality, and prevents other suitable remedies from being effective.

In short, I think that there is so much value in the intelligent use of arsenic that it seems a sin to allow its association with that time-honored humbug, promiscuous blood-letting, as an appropriate analogy to pass unchallenged.

1 PARK AVENUE, July 1, 1886.

---

**TREATMENT OF CHRONIC URTICARIA.**—In the treatment of this obstinate and distressing affection, Vidal recommends the bromo-hydrate of quinine, in doses of seven and one-half to fifteen grains, so as to secure the physiological effect of the drug. This should be continued fifteen consecutive days. The treatment should then be suspended and, if necessary, resumed again in a few days. Always a marked improvement, sometimes a complete cure is thus obtained. As a local application for the itching, he recommends lotions of a saturated solution of chloroform in water, the parts to be sprinkled with powdered starch before they become dry.—*Journ. de Méd. et de Chir.*, June, 1886.



## THE QUESTION OF THE VALUE OF ARSENIC IN DISEASES OF THE SKIN.

BY

W. A. HARDAWAY, A.M., M.D.,

Professor of Dermatology in the St. Louis Post-Graduate School of Medicine and in the Missouri Medical College; Ex-President of the American Dermatological Association.

THE editor of this JOURNAL has asked me to write a brief paper giving my personal experience as to the value of arsenic in skin diseases.

I shall willingly comply with his request in the hope that others may be induced to do likewise, and that, in this way, we may get at some definite conclusions regarding this vexed question of therapeutics.

For obvious reasons, which need not be entered upon here, it is a matter of the extremest difficulty to satisfactorily determine the precise indications for therapeutic agents, and the history of the employment of arsenic in diseases of the skin affords us a striking illustration of the truth of this observation.

As Morris<sup>1</sup> has stated, a study of the literature of this drug is unusually interesting, as exhibiting the "alternate excessive confidence in and excessive suspicion of it at different periods." As an example of this in our own day, we may note, on the one hand, the extreme credulity of Hunt, and the rather supercilious scepticism of Hebra.

I do not know of a better way of arriving at an expression of opinion in reference to the use and abuse of arsenic in dermatological practice than by offering a somewhat running commentary on the propositions recently presented by Dr. G. H. Fox to the New York Dermatological Society in a paper on the "Value of Arsenic in Skin Diseases,"<sup>2</sup> which I shall take up seriatim :

1. "*The very common practice of giving arsenic in nearly every case of skin disease is irrational and harmful.*"

This general statement will undoubtedly be accepted by all educated physicians, for a moment's reflection will show that cutaneous affections acknowledge the most varied etiology and present the most diverse pathological conditions, and no single remedy could by any possibility be of service in all, and would most likely prove injurious to some of them.

2. "*It is irrational because, in the majority of cases, the remedy produces very little, if any, benefit.*"

This second proposition follows as a corollary from the first; for cer-

<sup>1</sup> "The History and therapeutic Value of Arsenic in Skin Diseases." Practitioner, 1880. I am much indebted to this valuable article for various facts relating to the history of arsenic.

<sup>2</sup> JOURNAL CUTAN. AND VEN. DIS., June, 1886, p. 179.

tainly, if the usefulness of the drug is restricted to a comparatively small number of maladies, it would be irrational to employ it in the majority of cases where little or no benefit could be reasonably expected from its administration.

3. "*It is harmful for the following reasons: a, In many cases it increases cutaneous congestion, intensifies pruritus, and thereby aggravates the eruption; b, It is very frequently relied upon to the exclusion of other and better plans of treatment.*"

To the first half of the proposition I would give a very hearty assent, since clinical experience is here supported by experimentation. Ringer and Murrell found that when frogs were poisoned by arsenic, the cuticle could be stripped off the whole body with great ease within a few hours after its administration. Certain experiments by Miss Nunn prove that "the general effects of arsenious acid upon the epidermis is to cause a degeneration and partial solution of the protoplasm of the cells, whereby (1) the whole epiderm becomes loosened from the subjacent derm, (2) the cells of the Malpighian layer become incoherent, so that the whole layer collapses and its well-known architectural features become obscured, and (3) the intermediate layer separates from the Malpighian layer below, and at times from the corneous layer above."<sup>1</sup>

A consideration of the bearing of these important investigations on the remedial employment of the drug will show that its use is interdicted in acute cases, as it "increases metabolism in the cells of the epidermis" (Brunton), and consequently increases cutaneous congestion, intensifies pruritus, and aggravates the symptoms generally. As stated above, clinical experience amply confirms these researches, and it is with me an almost every-day occurrence to have my attention called to cases that have been made worse by the injudicious prescription of arsenic.

The second half of the third proposition (subhead *b*) is also undoubtedly true; thus, if arsenic is relied upon for the cure of a parasitic affection of the skin, and no appropriate local treatment is instituted, we are surely doing more harm than good. I take it, however, that Dr. Fox meant this statement in a somewhat different sense. I rather believe that here he refers to the large number of cases where arsenic is administered in a routine manner, as in some occult way "good for skin diseases," when such cases urgently require to be treated symptomatically and as regards their individual necessities. For example, a rosacea is often caused or kept up by some disorder of the stomach or uterus, and in such instances it would be the part of good practice to remove the exciting cause; but only too often this blind confidence in the efficacy of arsenic will lead to a neglect of the proper measures.

<sup>1</sup> Quoted by Morris, loc. cit.

As Niemeyer once said of blood-letting in pneumonia, that he sometimes bled in spite of the pneumonia, I think I may make this concession to arsenic, that I sometimes give it in spite of the apparent contra-indications to its use. In addition to its local effect upon the skin, arsenic also has a certain definite general action; therefore, in cases where I have had no desire to obtain its especial local influence, I have administered it for its modifying effect upon the economy, and especially the nervous system, and at times also when I wished to avail myself of its anti-periodic properties. But even here I should wish to postpone its employment until the acuteness of the cutaneous symptoms had somewhat abated.

4. "*The universal employment of arsenic in the treatment of skin diseases is no more a proof of its value than was the former practice of venesection for most diseases a valid argument in favor of that plan of treatment.*"

This proposition may be allowed to stand without comment. I may be permitted incidentally, however, one statement which relates to the reason of the widespread belief in the utility of arsenic for skin diseases. It has often happened in the history of medicine that when, in some way or other, a certain plan of treatment had been found advantageous in a given disease, all other cases of the same disease, or all diseases bearing a likeness to it, were immediately subjected to the same treatment, and as a proportion of the whole number answered the indications, the drug or plan of treatment soon became looked upon as nearly specific. This was far truer of former times than of the present, when the art of diagnosis is better understood, and is still in a measure true for dermatology, where skill in diagnosis is not a general accomplishment. Thus when Girdlestone, in 1806, first advocated the use of arsenic in psoriasis he hit upon the disease in which, in its chronic stages at least, it is of value and, therefore, when it was seen that it had a marked modifying influence on a "skin disease," and the differential diagnosis of cutaneous diseases not being well understood, it naturally came to pass that arsenic was soon looked upon as appropriate to all apparently similar troubles. A parallel case has arisen in our own days and, strangely enough, concerns the same disease. I refer to the use of chrysarobin, which, on account of its utility in psoriasis, is largely prescribed in general practice for nearly all skin diseases, and I must say to the great detriment of the patient.

5. "*The beneficial change which sometimes follows the use of arsenic is frequently due to adjuvant treatment and erroneously attributed to the administration of this drug.*"

6. "*In spite of the wide-spread belief in the value of arsenic, there has never been published a series of carefully recorded cases in which the sole administration of this drug has produced any notable therapeutic results.*"

These two propositions may be considered together. Undoubtedly it is true that for a large proportion of cases of skin disease the adjuvant treatment—and there is nearly always some such assistance—has done more good than the arsenic, and consequently most of the recorded cases in which arsenic was presumably the sole agent employed are worthless for purposes of study, since in the majority of such instances the diet and general hygienic surroundings have been looked after, and very frequently local applications have been employed. I shall delay consideration of those cases in which arsenic alone has apparently effected cures until we have examined Dr. Fox's next proposition.

7. "*There are some forms of chronic inflammatory skin disease, and possibly some affections of a malignant type, in which the internal use of arsenic will undoubtedly exert a beneficial influence.*"

To confine our attention first to the non-malignant group of diseases. As a result of clinical experience, fortified as it is by experimental proof, every dermatologist will readily admit that the internal use of arsenic will cause the disappearance of certain chronic inflammatory disorders of the skin, such as psoriasis, lichen planus, perhaps pemphigus, and probably a few others. After admitting so much, the question comes up: Are these results invariable; and if they are, are there no other plans of treatment that are quicker and better? Speaking from my own experience, I must say at once that arsenic often completely fails in the very diseases in which *a priori* we should expect the best results. In an excellent paper on the "Limitations of Internal Therapeutics in Skin Diseases,"<sup>1</sup> Dr. J. C. White uses the following language in regard to arsenic: "There is scarcely any affection in which it is not given by the profession with routine constancy. Its powers, however, are unfortunately very limited. For outside of this group (inflammations) it may be said to be powerless, while within it its action is positively injurious in the most inflammatory states of the skin, and of real service only in a very small proportion of the affections included in it. When I mention psoriasis, chronic eczema, lichen ruber, and pemphigus, I have named all of them in which we can confidently rely on it in any great measure. Even in these we know how often it utterly fails to accomplish what we expect of it, and how impossible it is to predict in any individual case, however favorable apparently, the measure or rapidity of its success. Upon the permanency of its influence in the recurrent forms of these diseases we cannot depend."

Mr. Jonathan Hutchinson vaunts arsenic as a specific in pemphigus but neither Hebra nor Tilbury Fox found it to be such. The latter expressly declares that "there is no specific for pemphigus. Arsenic is de-

<sup>1</sup> Archives of Dermatology, April, 1882.



clared to be one, but it often signally fails to cure the disease, and I have seen quinine in full doses do much more good."

Such has been my own observation, and in a case of pemphigus foliaceus under my care everything failed to benefit the patient. I may also say in this place that I have never seen the slightest good come from the use of arsenic in eczema or acne, except when the indications for its use were found elsewhere than in the skin, and then only in a limited number of cases.

Indeed, nearly all the chronic cases that come under my care have already taken the drug for long periods and in various doses. Acting upon a suggestion of Piffard's, I think, to the effect that a minute dose might accomplish what a large dose failed to secure, I have given arsenic in infinitesimal quantities in acute affections, but, I am sorry to relate, also without effect.

Admitting, however, that arsenic, even when given by itself, is capable of removing certain chronic inflammatory skin diseases—and this I have already acknowledged to be the case—I must still repeat my former question, viz. : Are there no other plans of treatment that are quicker and better? I must emphatically answer in the affirmative. While I know that arsenic will very often cause the disappearance of a psoriasis, I place infinitely more reliance on the local treatment, and if I were restricted to the one or the other, I should elect to use the latter. By the employment of local measures in psoriasis—*e. g.*, chrysarobin—the mode of action is about the same as comes from the internal administration of arsenic, with this advantage, that it is quicker and more direct; and I am confident, from much experience in the matter, that relapses are not more frequent under one régime than under the other.

I am aware that arsenic has been looked upon as a sovereign remedy in lichen planus, and especially good results are said to have been obtained by its hypodermic administration (Koebner); but here also it has been known to fail, and lately Unna has claimed much more rapid relief from purely local measures.

As regards the curative influence of arsenic on the malignant affections of the skin, it is a matter of medical history that the drug has been given in cancer, real or supposed, from the date of its first introduction into therapeutics; but I doubt very much if any modern surgeon would pin his faith to it. Not a great while ago, the profession was surprised and delighted with the report of Prof. Koebner's cure of a case of sarcoma cutis by the subcutaneous injection of arsenic, and while there is no sort of dispute as to the correctness of the diagnosis, or as to the results obtained, the query arises: Will such a happy issue be invariable? Unfortunately, in my own practice, two cases of sarcoma of the skin treated by arsenic—one only by the hypodermic method—were examples of con-

spicuous failure. Nevertheless, I should try it again, if the opportunity offered.

8. "*In most cases of inflammatory skin disease, regulation of the diet, and such hygienic and medicinal treatment as tends to improve the general health of the patient will do infinitely more good than the routine administration of arsenic.*"

The essential statements in this last proposition have been sufficiently considered in the foregoing paragraphs; it is, therefore, only necessary to express a general assent to its conclusions.

Finally, I would say that I am far removed from therapeutic nihilism, and that I believe we have many agents which, when taken internally, are capable of influencing pathological conditions; but what I would most earnestly protest against is the crude idea of specific medication. There can be no such things as specifics, and a rational therapeutics must be based upon an intimate knowledge of both healthy and morbid processes. Therefore, to prescribe arsenic as in any wise a panacea for the majority of skin diseases, merely because of its efficacy in some of them, is highly unscientific and much to be deprecated.

## MOLLUSCUM CONTAGIOSUM—AN ANALYSIS OF FIFTY CASES.

BY

CHARLES W. ALLEN, M.D.,

Surgeon to Charity Hospital.

“**M**OLLUSCUM contagiosum is so-called because it is *not* contagious.”

I find this statement in my notes, taken at the clinic of an eminent professor of dermatology in Vienna a number of years ago.

Dr. Fox stated, at the meeting of the New York Dermatological Society, April, 1876, that he had never seen contagion, although children having the disease had slept with others under his observation. In his excellent paper read before the American Dermatological Association, 1877, he goes so far as to admit that “the remarks applied to warts that they appear sometimes to be contagious might equally well be applied to molluscum.”

Kaposi says positively that there is no ground for considering the disease contagious.

Duhring does not commit himself, but prefers the name *molluscum epitheliale*.

Robinson says: "In spite of its name, the malady is in no way contagious."

I am not acquainted with the precise views of many of our American dermatologists on this question, but I know that there exists a great diversity of opinion.

Opportunities for studying the disease are not frequent, in this country at least, and none should be neglected which may help clear up the nature of an affection which, since its first description, has borne a name believed by half those using it to be a false one.

In February, 1883, there came to the New York Hospital a married woman, 25 years of age, to be treated for a group of molluscum tumors on the right side of the neck and a few scattered ones on the opposite side. They had first appeared, she said, seven months before, on the right side, at a spot where her child, who had also had the disease, rested his face when she carried him.

The child was examined, and found to have still remaining upon his face a solitary molluscum. The mother stated that her small brother, who lived in the family, was similarly affected. Here was almost the counterpart of one of the cases which led Bateman, in 1817, to give to this variety of molluscum the name *contagiosum*.

Dr. Bulkley inoculated my left arm in two places with some of the substance of the molluscum and the sebaceous-like material pressed from its central opening. For a week or ten days, I kept the spot carefully protected. After the irritation caused by the operation had all passed away, there gradually appeared at one of the points inoculated a little papule, which became elongated, flattened, and of a pink hue. It gave promise of developing into something, and then disappeared. I regarded it as an abortive attempt at reproduction.

Retzius claims to have inoculated the disease upon his own person.

Vidal reported to the Soc. de Biolog., *Prog. Méd.*, 1878, that in two cases inoculated molluscum had been produced; in one appearing in three months, and the other in six months after the inoculation.

Dr. Paterson, of Leith, claims to have practised inoculation successfully.

These reports do not appear to have carried much weight with them, for authors still say that inoculation has never succeeded.

Early in March of this year, I was called in consultation to one of the infant asylums of this city in which some skin disease had attacked almost a hundred of the children. I found them to be suffering from scabies, and some were in a pitiable condition. In making my examination, I discovered a case of *molluscum*, and being told by the matron that

many of the girls were similarly affected, ordered all such to be brought up. Some thirty cases were found at once.

From the matron, I learned the following history of the outbreak:

When Polly H. came into the institution one year ago, they noticed that she had these peculiar looking warts on her face, but gave no further attention to them. After she had been here for about three months, it was observed that not only had the growths enlarged and multiplied upon Polly's own face, but that many of the other girls were



similarly affected. In the matron's own words: "So you see one girl brought it in, and the others caught it from her." What more reasonable inference could be drawn?

I operated upon forty-two children, at several sittings, removing 133 tumors, of which I kept record, besides some smaller ones. They were distributed as follows: Eyelids and regions about the eye, 51; other



regions of the face and neck, 51; nose, 11; lips, 11; hand, 4; chest, back, arm, knee, leg, each 1.

The largest one was on the chest, and measured a centimetre in its longest diameter. The smallest were discovered on the vermilion border of the lips in two cases. They are shown in the engraving, which I would say is not the representation of a single case, but exhibits the actual lesions of several separate cases, accurately located and painted from nature.

The growths were removed for the most part with sharp spoon or dermal curette. A few were incised, pressed out between the fingers, scraped out with the finger nail, or pulled out with dressing forceps. Some were also cut off even with the skin's surface, and the deeper part pressed out. In most cases where the remaining cavity was not scraped out, it was touched with the solid stick of nitrate of silver. The patients, all being girls, I was anxious not to leave scars or staining, and hence used the caustic stick sparingly, relying upon the sharp spoon. When scraped out whole, the growths have a peculiar, gland-like structure, and resemble a diminutive brain.

Among the children sent to me as being affected with molluscum, I found some to have only verruca vulgaris, or common warts, the nurses and the children themselves considering them all of the same variety. This co-existence of similar growths impressed me at the time, and I examined all of the cases in reference to warts. Sixteen were found, eight being in patients entirely free from molluscum and eight in children having the disease. On the arms of several of the patients I found a flat variety of wart with a pink border, which resembled the mollusc tumors in a measure, but had no central opening, were of firm consistence, difficult to remove, and did not present the gland-like structure. They were also situated on parts not commonly occupied by warts, and in one case formed a small group. I have since read the paper of my friend, Dr. Fox (American Dermatological Association, 1877), in which he speaks of this co-existence of verruca and molluscum, and suggests a possible common cause or some close connection. We must, however, remember that warts are very common in children, and molluscum but rarely encountered.

This is a larger number of cases occurring together than I find anywhere recorded as having been observed, and I took advantage of the favorable opportunity thus afforded to make some observations on the nature of the disease.

Regarding the result of the previous inoculation practised upon myself as an abortive effort at reproduction, and considering the clinical history of the disease to warrant the belief that it is sometimes propagated by contact, I inoculated two of the children with the soft substance from

a molluscum tumor, and some of the firmer part as well. I chose those who had had the disease, as being the most likely subjects, and made the inoculation on the face, protecting one point for some days with a watch glass, and gave instructions for certain precautions to be observed. Three months later no signs of reproduction had appeared.

Upon visiting the institution on June 19, over three months from the date of operation, I found that twenty-eight of the children treated had remained entirely free from the disease, four had left the institution well, twelve children presented new crops of mollusca, in four instances scattered about the neighborhood of original lesions, but none at their actual site. In several instances the growths had appeared on entirely new regions.

They were all situated upon the face and neck with the exception of one solitary lesion upon the shoulder. No scars were discoverable as the result of operation.

Besides these twelve cases in which the tumors had reappeared, there were found five children, not previously affected, in whom they had developed.

The inoculation of the children having so far resulted in nothing, I now inoculated myself again in two places upon the soft skin of the flexor surface of the forearm, and have since kept the part covered with a watch glass, and somewhat moist. Some pain was experienced for a few days in the arm and axilla following the procedure, and the epitrochlear gland was painfully enlarged, and is still quite tender. I will make known the result at some future time, together with anything worth reporting, from my efforts to discover the microbe of molluscum, whose existence I think highly probable.

It has been suggested that irritation of the skin is a potent factor in the production of the disease, and it will, without doubt, occur to those who hold this view that in this series of cases the most favorable conditions for its development existed. Here we had an epidemic of scabies with all the attendant surface irritation.

I cannot think, however, that this irritation alone is sufficient to cause the disease. Over a hundred of the children suffered from scabies, while less than fifty had molluscum. Many of those who had molluscum did *not* have scabies, and in other respects their skins were healthy and free from irritation. The faces thickly studded with mollusca were, as a rule, remarkably free from scabies, while scarcely a tumor was found upon the scratched and irritated body.

Other writers have claimed that maceration of the skin and frequent bathing greatly favors its production. All of these children were regularly bathed, and those with scabies quite frequently, still it is safe to say that none of them had as much attention paid to the cleanliness of

the body as the children of the better class, in whom the disease is rarely seen. On the contrary, molluscum is commonly found in poor and uncleanly families. It appears to me, however, that maceration or moistening of the surface from perspiration may favor the propagation of the disease by contact, as when the face of an infected child presses against the mother's face or breast, thus producing a more favorable nidus for the contagious principle.

I do not wish at present to touch upon the pathology of the disease, but would regard the existence of mollusca in the cases mentioned upon the vermilion border of the lips as a strong clinical point against the theory and belief of some that molluscum contagiosum has its origin in the sebaceous glands. I believe that no sebaceous glands are to be found in this portion of the lip. Nor yet would it appear that the disease can, in all cases, originate in the hair follicles.

Virchow, Bizzozero, Piffard, Robinson, Perls, Thin, and others oppose the view of Hebra, Kaposi, and their followers, that the disease is of sebaceous origin.

In fifteen tumors examined by Thin, hair or sebaceous gland structure was found in but one case. One of the tumors is shown in the drawing on the upper eyelid, pierced in its centre with an eyelash. I removed the tumor and hair together, but have not yet made a section for examination.

In conclusion, my present reasons for believing this molluscum contagious, and that its name is a proper one, and should be retained, are:

1. The cases reported by Bateman, Mackenzie, F. Fox, Liveing, and others, and the first one mentioned in this paper, where the child first has the disease, and the mother afterward, upon the face, neck, or breast, are difficult of explanation by any other theory.

2. The spread of the disease in families, schools, and institutions. Liveing (*Lancet*, Oct. 5, 1878) reported nine cases occurring coincidentally in a school.

3. The facts that the parts exposed to contact are those almost solely affected: The face in children, the breasts in mothers, and the genital region in adults, and especially in prostitutes and the men who visit them.

4. The reported successful inoculations.

5. That negative evidence has no weight. It is not always possible to inoculate other diseases which are well known to be contagious.

Finally, the disease should never be mistaken for any other, although Bazin considered it sufficiently like variola to name it *acne varioliformis*. It bears a slight resemblance to varicella, and when occurring upon the genitals has suggested syphilis to those unfamiliar with its appearance. From molluscum fibrosum the diagnosis is easily made.

## Correspondence.

### TREATMENT OF RHUS-POISONING.

SAN FRANCISCO, Cal., June 19th, 1886.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

SIR:—Living in a country where rhus-poisoning is quite as prevalent, if not more so, than anywhere else, it is but natural that we should feel interested in this subject, and that everything bearing upon it should attract our attention, more especially so when we see an article referring to it, so ably written as the one which appeared in the June number of your journal. Poison oak is very abundant in the country around San Francisco, and is also found for hundreds of miles in every direction from this city. It is the very bane of our camping and picnic parties, in fact, of all whom business or pleasure calls into the country. As is well known, some are poisoned by it from simply passing in the neighborhood where the shrub grows, while others again enjoy such an immunity from its effects, that they can handle, or even chew its leaves and branches, without ill effects. As there is no specific for the cure of this affection, and as all remedies fail us now and then, our physicians out here are continually trying all therapeutic means to obtain one which will be invariably successful. All the remedies that you have mentioned in your paper, and many more, have been tried. I wish to call attention to one means of treating this affection which I have not seen mentioned in print, which is more efficacious than any other with which I am acquainted, to wit: Russian baths. I am convinced, not only from an extensive trial in my own practice, but also from the reports of my colleagues who have used them in this trouble, that they excel for efficacy and rapidity of good effect any other mode of treatment. It may be stated, as a general proposition, that they are the treatment *par excellence* for poison oak. My friend Dr. Loryea, of the New Hammam, of this city, formerly of the Windsor Hotel baths, of New York, who has also employed them in hundreds of these cases, informs me that he has had excellent results, and that they rarely fail to afford immediate relief. A number of baths may be required. Sometimes it may be necessary to use in addition a mild protective ointment containing zinc, bismuth, or lead—the baths, however, being the basis of the treatment. The beneficial effects of any lotion will be materially heightened if it be applied warm, provided that it be one adapted to the case.

Trusting that I have not trespassed too much upon the time and patience of your readers, I remain,

Yours fraternally,

ALFRED E. REGENSBURGER, M.D.

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

#### Chronic Œdema of the Lids and Eczema of the Nose.

IN one of the last meetings of the clinic of the St. Louis Hospital, in Paris, Dr. Besnier spoke of the nature and pathogeny of certain chronic œdemas of the eyelids, especially of the lower lids, which come to resemble puffy cushions. The face also presents a certain amount of swelling. When the patient is first seen, one naturally thinks of a renal affection, which the examination of the



urine shows to be unfounded. Formerly these lesions were attributed to erysipelas, or rather to repeated attacks of lymphangitis, and, indeed, we sometimes observe inflammatory phenomena. The labors of Dr. Vérité have shown that the greater part of these chronic œdemas of the lids have a close connection with chronic eczema of the nares. If this eczema is propagated in a downward direction, it may cause fissures, and more especially a thickening of the upper lid, which is so often met with in strumous subjects. When, on the contrary, it spreads upward, it produces the œdematous infiltrations of the eyelids of which we have spoken. It must not be understood that eczema of the nares is the only lesion which can produce this condition, for it is also observed in lupus and syphilitic lesions of slow development which affect these parts.

These varieties of eczema are of the most rebellious character. Dr. Besnier advises a general treatment, with cod-liver oil in winter, and in other seasons arsenic, together with topical applications, if necessary.

Frequent spraying of the nares with tepid Saint Christan water is beneficial, or, if this mineral water cannot be obtained, with tepid water containing from fifty centigrams to a gram of sulphate of copper in each quart.

In the intervals of the spraying, small pledgets of cotton should be introduced within the nares, spread with an ointment containing ten grams of diachylon ointment to each twenty grams of vaseline or oil, or with an ointment made with a gram of yellow precipitate to each twenty grams of vaseline (Vidal).

Some cases of œdema of the lids are so marked that we should produce punctures at the most tumefied points, with the finest Paquelin thermo-cautery. By this treatment the swelling is reduced with much greater rapidity.

### Eczema of the Anus.

We all know to what extent eczema located in the region of the anus can be tenacious and obstinate, and we are often consulted, by arthritics in particular, who have been affected for years, and in whom the skin of the perineum, of the margin of the anus, and of the anal commissure has finally thickened under the influence of repeated inflammations. We are now considering a condition to which the old French writers gave, with so much reason, the name *eczema lichenoïde of the anus*.

To cause this lesion to disappear, and to prevent relapse, we must take a number of precautions. Besnier, in his clinics, recommends his patients to take an enema of tepid water after each passage, retaining it but a moment; and to wash the parts frequently with tepid water, in order to remove all irritating matters. At night a slightly warm cataplasm made with potato-starch powder or flax-seed meal should be applied. If the pruritus is intense, pledgets of lint smeared with cocaine ointment may be introduced into the anus. The patient should abstain from spicy dishes, and especially avoid pepper. I will add to the recommendations formulated by Besnier the following observations:

It is absolutely necessary that direct contact should be prevented between the affected parts. The cataplasm must, therefore, be introduced at night, deep into the groove between the buttocks. During the day the affected parts should be covered with an ointment of oxide of zinc of the strength of thirty grains to the ounce of vaseline, and over this should be sprinkled oxide of zinc and subnitrate of bismuth in equal parts, finely powdered; some old fine linen, also powdered over with the same, is to be placed deeply in the groove between the buttocks. Bathing trunks furnish an excellent means of retaining the dressing in place. In

rebellious varieties of the disease, these soothing methods of treatment will not produce a cure in every instance. It becomes at times necessary to treat these lichenoid eczemas of the anus by applications of oil of cade in twenty, twenty-five, and fifty per cent ointment, or with a three to six per cent nitrate of silver wash. If these means cause too violent inflammation, they must be replaced, for a time, by poultices and soothing ointments, to be resumed again, and in this way, in almost every case, a cure will finally be effected.

### Lichen and its Treatment.

We find the following mode of treating lichen formulated by Dr. E. Vidal in his recent article (*Annales de Dermat. et de Syphiligr.*, 1886), à propos of certain varieties of circumscribed lichen, and in particular that form which he designates by the name of chronic lichen of the genital and anal regions. This, in reality, is nothing more than the inveterate form of what I have just designated under the name of lichenoid eczema of the anus. It is well known that the researches of Hardy and of the Vienna school destroyed the old group lichen. Hardy places it among the eczemas, and Hebra less exclusively described certain forms of it under the name prurigo. Lichen ruber, which is a special affection, cannot be cut out of the nosological tables, and as to lichen scrofulosorum, for which the Vienna school preserve the name lichen, it is undoubtedly only a variety of acne. Dr. Vidal protests against this conception of the lichenoid lesions of the skin. He clings to the old group "lichen" of the French writers, but no longer classing under it lichen pilaris, which is only an exaggerated degree of xeroderma, nor lichen scrofulosorum.

He admits two principal varieties of lichen.

1st. Lichen simplex which may be: A *acute*, or B *chronic*. A. Acute lichen simplex is, a, *partial*, or b, *general*. This category includes the lichen simplex of authors; lichen lividus and the most of the strophulus group, excepting the strophulus albidus, candidus et volaticus, which are only in reality urticarias, and excepting strophulus having large papulo-vesicles which are probably polymorphous erythemas occurring in infants. B. Chronic lichen simplex can also be *partial* or *general*, and in this group also are included lichenoid eczemas or the chronic lichens formerly described, according to their form, under the name lichen circumscriptus, perpendicularis, and gyratus, which develop on the neck, buttocks, genital regions, etc.

2d. The second great variety of lichen described by Dr. Vidal is polymorphous lichen. He divides it into two sub-varieties. A. *Lichen polymorphus mitis*, comprising lichenoid eruptions of quite rebellious character, often *professional*, such as baker's itch, grocer's itch, and that seen in workers in factories who handle irritating substances, etc. B. *Lichen polymorphus ferox* which corresponds to the lichen agrius of the old writers, and to the true prurigo of Hebra and the Vienna school. In this connection the author protests against the name "Hebra's prurigo," which most French dermatologists have given to this affection. He well remembers that before the publication of the Vienna school, this disease had been perfectly described by Cazenave, Bazin, and Hardy. He also thinks that we should preserve its name lichen. He makes of it an ordinary lichen, modified in its appearance and clinical aspects by the terrain, at the same time scrofulous and nervous, on which it develops. I will not enlarge further upon the views of Dr. Vidal nor upon the discussion which they elicited, but the preceding explanations were necessary in order to characterize the forms of

affection in which the therapeutic measures brought forward by this author should be applied. In the internal treatment of the different varieties of lichen, he especially recommends a rigorous regime, abstinence from coffee, tea, wine, and liquors; the avoidance of loss of sleep, fatigue, violent emotions. The exclusion from the dietary of salty food, pork, game, salt cheese, shell-fish, and sea food generally.

Whenever the itching becomes violent and causes sleeplessness, opium may be administered by the mouth or by hypodermic injection, or bromide of camphor, bromide of potassium, or chloral given, provided that in the latter case alcohol is not used with it, as a chloral erythema might thus be produced. The author has succeeded very well in such cases with valerian castoreum, and in some rebellious cases with musk in daily doses of a drachm of the tincture.

Dr. Vidal believes that arsenic may be efficacious in chronic lichen simplex, and he prefers to administer it in the form of arseniate of soda.

R. Sod. Arseniat .....	0.10
Aquæ destillat. ....	100.

M. Sig. Teaspoonful in the morning before breakfast; after seven or eight days two teaspoonfuls.

Arsenic does not succeed so well in polymorphous lichen (prurigo of Hebra), especially when given in large doses. I will not dwell upon the author's treatment of acute lichen simplex; it is that of the older French dermatologists, excepting perhaps his vinegar and starch baths (a quart of vinegar to the bath), and lotions of decoction of slippery elm root, to which are added a fifth or a quarter part of vinegar or alcohol.

The skin is to be rapidly moistened with this wash, then, without drying, powdered over with starch powder, or with a mixture of starch powder 4 parts, and of oxide of zinc 1 part.

In chronic lichen simplex, the author employs extensively an ointment composed of tartaric acid, one gram, to twenty grams of glycerole of starch, made with Price's neutral glycerin. In obstinate cases he resorts to the methods which I have mentioned in speaking of lichenoid eczema of the anus.

In the forms which correspond to the prurigo of the older writers, which are characterized by disseminated and very large papules and by intolerable itching (prurigo simplex, senilis, and ferox), the author prescribes bathing with the following solution:

R. Hydrat. Chloral.....	5 to 10 grams.
Aq. Laur.-Ceras.....	50 grams.
Aquæ.....	200 grams.

In some cases saturated chloroform water, or a solution of bromide of potassium, or finally hot water, to which camphorated alcohol has been added, greatly relieves the patients. In the most obstinate cases we must resort to the treatment employed in polymorphous lichen (Hebra's prurigo).

Dr. Vidal enters into minute details regarding the treatment of the latter affection, and calls to mind the practice of Hebra which consisted, as is well known, in frictions with cod-liver oil, sulphur soap or tar, and sulphur combined, etc. Kaposi's treatment, with naphthol ointment in from three to five per cent strength, also that of the former physicians of the St. Louis Hospital, who submitted their patients to applications of oil of cade, phenic and salicylic acid,

diachylon ointment, Wilkinson's ointment, and occasionally sulphur baths, and the routine treatment for scabies. After many trials we have come to employ cod-liver oil extensively at the St. Louis Hospital. Its introduction into the therapeutics of this affection, by the way, is not due to Hebra, but to French dermatologists, since we find this method mentioned in the works of Gibert.

Dr. Vidal has rendered a real service to medicine in having made a plaster of cod-liver oil, which greatly facilitates the application of this substance. The formula is: simple plaster with litharge and cod-liver oil, 600 grams; yellow wax, 250 grams; cod-liver oil, 350 grams; dextrin, 20 grams; water enough to dissolve the dextrin. This plaster has given him excellent results, not only in polymorphous lichen (prurigo of Hebra), but also in all other obstinate lichenoid affections of the skin. He has used with equal service the following: simple plaster, 600 grams; yellow wax, 250 grams; white oil, 400 grams; dextrin, 20 grams; water enough to dissolve the dextrin.

This ointment must be kept free from moisture. I am convinced, for my part, that cod-liver oil is the drug for Hebra's prurigo (lichen polymorphus of Vidal).

I have succeeded in curing a little girl of five years, whose parents had not seen her face since the age of sixteen months, as since this time it had been a mass of crusts covering a raw surface.

I gave the child from three to six dessertspoonfuls of the oil per day, and covered her from the head to the feet with the same. At points where too much itching is caused I followed the advice of Dr. Besnier, in applying naphtholated cod-liver oil. Naphthol  $\beta$ , 10 grams; cod-liver oil, 100 grams. This mixture calmed the pruritus in a marked degree.

At night the child was tied on the bed, with feet and hands attached to the railings, so that during sleep she could not wound herself by scratching, which she always did when left free. I believe we must not content ourselves with making external applications of cod-liver oil, but must give it internally as well.

Dr. Vidal thinks these patients are benefited by weak sulphur water, and advises their being sent to Uriage, St. Gervais, and to the sulphur springs of Luchon. In the most inveterate cases prolonged baths of Louèche (Valais, Switzerland) may be found useful.

### Treatment of Psoriasis.

In one of his recent clinics, Dr. Besnier dwelt upon the fact that, no matter what therapeutic measure may have been employed in certain cases of psoriasis, there sometimes remain for a long time, at points where plaques have existed, brown pigmentations, which the older writers attributed exclusively to arsenical treatment. While admitting this as perfectly true, I think I can add that these macules are much less frequent when oil of cade is employed than when either chrysophanic or pyrogallic acid is used. Dr. Besnier likewise remarks that we cannot formulate for psoriasis a unique medication which will apply to all cases. The means must vary with the period of disease, its distribution, and the degree of irritation of the skin. This is the means he now recommends when we have to treat a discrete eruption characterized by a few scattered patches.

Cleanse the psoriatic patches with the greatest care by means of repeated baths and frictions with brush and soap; then rub the diseased points with a brush impregnated with a ten-per-cent pyrogallic acid ointment, then leave on the spot a layer of ointment as thick as a case-knife blade, and cover it over with a flannel bandage. In five days, the whole is to be removed, a bath given, and



the treatment repeated. When this dressing is made with care, only four or five applications are required to bring about complete disappearance of the disease.

But when the surfaces treated are quite extensive, the urine must be carefully watched, as the absorption of pyrogallic acid might cause serious trouble. I have experimented in my service at the Hôtel Dieu, at the time I had the honor to replace Dr. Moutard Martin, also in the service of Dr. Vidal, at the St. Louis, with the various means of treating psoriasis. I believe that for psoriasis characterized by a few isolated patches, the application of Vigo's plaster with mercury constitutes one of the best modes of treatment. The plaster is left applied to the part for two days, then removed, the parts bathed with black soap, and a new piece of mercurial plaster applied, and so on till the plaque has entirely disappeared, which takes place in from six to twenty days. A red plaster, formulated by Dr. Vidal, and composed of minium and cinnabar, 5 parts to 25 of diachylon, may also be used. Salicylic acid plasters, in ten or twenty per cent strength, which I have used, are much less efficacious. On the contrary, following Dr. G. Elliot's practice, I have experimented with collodion dressings composed of salicylic acid, 1 part; pyrogallic acid, 5 parts; collodion, 50 parts. I first cleanse the psoriatic patches, and apply the collodion, renewing it every two or three days, or whenever I see that it is becoming detached. I then give a bath, and apply another layer. This treatment is quite active, and among the most efficacious. In one instance, a single application sufficed to make the patch disappear. It is true that in this case the collodion remained adherent during several days, and caused marked inflammatory reaction, attended with severe pain. This method would be excellent were it not painful, and did it not irritate the skin of certain patients, especially those of strumous habit, in whom it determines inflammatory eruptions, phlyctenulæ, ulcerations, and lymphangitis, and also expose the patient to accidents of poisoning from the pyrogallic acid, such as I have seen from too extensive use of this collodion. I have also tried the following collodion: Pyrogallic acid, 5 grams; collodion, 50 grams, on the same patients who were using the above formula, treating the right side with the one and the left side with the other. I have found in this way that the latter collodion is less painful, less irritating, but a little less active than the former. Salicylic acid consequently increased the power of the pyrogallic acid. On the other hand, collodions with ten to twenty per cent salicylic acid, which I have used in the same way, are very painful and irritating, and much less efficacious than those of pyrogallic acid.

DR. L. BROCC.

PARIS.

---

## Selections.

---

### THERAPEUTICS OF SYPHILIS.

At the last "Kongress für innere Medicin," held at Wiesbaden, considerable attention was given to the above subject, in which Professor Kaposi, of Vienna, led in the discussion. He called attention to the fact that to-day, as four hundred years ago, mercury constitutes the standard treatment, and only a single addition has since been made to the therapeutics of syphilis. He did not hesitate to affirm, however, that not only was syphilis a curable disease, but that of

the different infectious, constitutional diseases, it was the one which, with proper treatment, was most easy of being thoroughly eradicated from the system. He propounded three questions, and proceeded to discuss each in its turn. His first question was:

*Is there any positive method whereby the primary effects of syphilis may be treated and an immediate eradication of the disease thus produced?*

If the initial step of the disease be viewed in its proper light, to wit: that the specific virus remains for a certain (although indefinite) time in the primary lesion, and is drawn up from here into the lymphatics and blood-vessels, three possible means present themselves of effecting the desired result. They are: I. The destruction of the virus at the point of infection in and with the primary lesion, by means of cauterization or excision. The objections to this are that we are absolutely without any data as to the time that the syphilitic virus may remain in a lesion before it is absorbed, and that even favorable results are not of statistical value because every sclerosis is not followed by the disease. Neither the presence nor the absence of glandular enlargements gives us definite data for knowing whether a primary lesion be syphilitic or not. If the relation of Lustgarten's bacilli to syphilis were fully demonstrated, their presence would doubtless constitute an effective criterion for the diagnosis of primary lesions. Excision is practicable when coupled with certain advantageous, topographical circumstances, as, for instance, if, on the margin of the prepuce, but almost wholly impracticable if on the glans or in the sulcus. Emplastr. hydrarg. is effective in the local treatment of the primary lesion. II. The disturbance or destruction of those vessels which constitute the immediate path of absorption of the virus. Prof. Kaposi thinks that whoever first made this suggestion should have accompanied it with more specific instructions. Which lymphatic vessel shall be severed? The whole penis lies imbedded in a web of lymphatics, and, without more exact knowledge, how can the prevention to be incurred by the very sweeping operation necessary under the circumstances be kept down to its traditional proportional ounce? III. Preventive measures. Although it is theoretically wrong to proceed with the eradication of a disease by first letting it fully develop, still he has observed that an early treatment does not prevent the subsequent appearance of tertiary symptoms, which, under such circumstances, often appear, and in severe forms. He urgently advises not to be too hasty with the mercurial treatment.

The second question was:

*What are the respective advantages of the different remedies used in the treatment of syphilis?*

Hospital statistics are of no avail, because the patients usually disappear as soon as the lesions have been removed; and since private statistics are not to be had, we are referred to individual cases, from which it is impossible to form comparative judgment. Mercury is applied endermically, hypodermically, and through the organs of digestion. Of endermic means, the inunction method with ung. hydrarg. is the most important. The plain ointment is the most reliable and efficacious means of treating early syphilis. Lanolin ointments and mercurial soaps (the latter of which is quite effective) are not as desirable as the first method. Intestinal affections and pyalism very infrequently accompany the application of the blue ointment, and by means of it is obtained a happy medium between absorption and elimination. Hg. plasters and Unna's Hg. plastermulls are generally of little use, but may be applied with advantage in the local treat-

ment of irritative and later syphilitic sores. Mercurial baths are very efficacious in the treatment of newly-born infants and adults suffering from ulcerous eruptions.

The hypodermic method is direct, exact, and convenient, and beside the original sublimate solution of Lewin a number of other preparations have been experimented with. The following three groups of Hg. remedies have been arranged by Bockhart with reference to their permanency :

1. Most permanent :
  - a. Inunction method (ung. hydrarg.).
  - b. Calomel injections
  - c. Lewin's sublimate solution
 } subcutaneous.
2. Moderately permanent :
  - a. Sublimate-chloride of sodium
  - b. Hg. albuminate and peptonate
  - c. Blood-serum mercury
 } subcutaneous.
3. Less permanent :
  - a. Hg. bichloride
  - b. Hg. glycolol
  - c. Hg. formamide
 } subcutaneous.

The formamide is the least painful.

Internally, the customary Hg. preparations (sublimate, calomel, and hydroxyd. tann.) act usually more slowly than the others ; still, they are quite effective, and especially the last causes but slight discomfort to the stomach. In France, proto- and deuto-iodide of mercury find great favor as internal remedies.

Mercury is best adapted for all forms of affections of the skin, both in the early and late periods, and in acute conditions of the bones, the parenchymatous organs, and of the cerebro-spinal system, whereas the later nervous affections of the joints and cephalalgia syphilitica yield decidedly more quickly to iodine treatment. The more promptly and actively treatment is begun in the first *acute* stage of the disease the less is the probability of a relapse. Therefore, inunctions, or, if these are not possible, injections should be energetically begun at the proper time, and the most permanent remedies should be selected. All slow-working remedies cause only a prolongation if applied in the acute stage. Only in case of later affections, such as localized papulous formations, may they be applied, but in affections of a dangerous nature, such as iritis, ulcerative nasal or throat affections, or those of the brain or spinal column it is essential to use the most energetic means, and especially the inunction method with ung. hydrarg.

Iodine is especially good in cases of bone and joint affections and also for nocturnal pains in the bones and in the head. It can also be prescribed for syphilitic symptoms during the later periods, but should *never* be used alone in the beginning of the disease, owing to the protracted course of eruptions which follow it. That iodine can be used as a corrective against the misuse of mercury is a total misconception and utterly without foundation.

Zittmann's decoction of herbs is a very potent measure for later stages, and especially for ulcerative formations of the skin and throat. Prof. Kaposi often combines the use of this decoction with inunction, and observes that the presence of Hg. does not affect its activity.

Sulphur-baths, sea-baths, and hydropathic treatment have not the slightest specific effect upon the disease.

*How long should treatment be continued?*

Concerning the third question, as to the length of time and the repetition of treatment, Prof. Kaposi advised a long and careful course for from three to six months, and to repeat the treatment only when relapses occur, and not in order to prevent them. He did not object, however, to a light course of treatment for safety's sake.

Prof. Neisser, of Breslau, did not agree with Prof. Kaposi in his views with reference to an advisable delay in the treatment. He believed in cauterization with concentrated carbolic acid, or, if possible, excision. He believed it advisable to use every opportunity for the prevention of the outbreak of syphilis, and destruction of its virus. He agreed generally with Fournier in his views, and in the treatment preferred, as he said, to recognize the individual, and fashion his treatment thereafter than to recommend any single system for all cases.

Prof. von Ziemssen, of Munich, recommended especially hypodermic injections of bichloride of mercury, and after a lengthy discussion Prof. Kaposi closed by expressing the hope that physicians generally might add statistics from their private practice, so that more extensive data may be available.—*Deutsche Med. Wochenschrift*.

**RESORCIN.**

THE *Centralblatt für die ges. Therapie*, March, 1886, contains the following observations concerning resorcin by M. Ihle, of Leipsic, reported by Jarisch. The specific antiseptic properties of resorcin can be best noticed in herpes tonsurans. After two or three applications of a strong resorcin ointment the inflammation is allayed, and if the plates of epidermis tanned by the resorcin are removed, it will be found that only in those hairy regions where the spores have made their way to the bottom of the hair follicles is it necessary to continue treatment.

A very great advantage in the treatment of parasitic sycosis with resorcin is that the beard need not be epilated, the hairs loosening of themselves under the treatment. The pastes used should be applied two or three times a week, thickly with a brush, and rubbed well into the parts, which are then to be covered with cotton. It is at all times well for the physician to apply the preparation himself, and increase the strength with the progress of the cure. For instance, if the first application is a ten-per-cent paste and causes no great irritation, the next may be of twenty-five per cent, and the strength may be thus gradually increased to fifty or eighty per cent, then when the pus formation and irritation begin to decrease, applications must be continued in decreasing strength, following a similar scale.

As spores may still exist in a case of apparent cure, it is advised to give the patient a three-per-cent salve to apply at first daily, and later on once or twice a week. Now, for the first, should shaving be permitted, because in the energetic treatment with resorcin, shaving should be absolutely forbidden on account of the irritation which it causes.

The following ointments are recommended.

R Resorcin purissim.....	10
Vaselini albi.....	50
Amyl. Oryzæ,	
Zinci Oxidi.....	25
M. ft. past.]	

With an increase in the amount of resorcin, it is necessary to decrease pro-



portionately the zinc and starch. Therefore, for stronger ointments, the following is used.

℞ Resorcin puriss.....	50
Vaselin. albi.....	60
Zinci Oxid.,	
Amyl. Oryzæ .....	āā 20
M. ft. past.	

The author speaks of resorcin in the treatment of pityriasis versicolor and eczema marginatum as being attended with absolutely sure results. He also recommends it in the treatment of alopecia areata and seborrhœa cum defluvio capillorum.

For these he uses:

℞ Resorcin puriss.....	5.10
Ol. Ricini.....	45.
Alcohol.....	150.
Bals. Peruv.....	0.5
M. S. Apply daily to head with a flannel rag.	

The itching of the seborrhœa is said to cease entirely under this treatment.

Condylomata acuminata treated with an eighty-per-cent resorcin salve, daily applied, quickly disappear. It is well to apply a five to ten per cent salve for some time afterward to remove the tendency to their redevelopment.

Dr. Ihle does not approve of the application of resorcin to eczema and other inflammatory skin diseases, because of its irritating properties.

Dr. Unna, however, in a pamphlet upon Ichthyol and Resorcin, Hamburg and Leipsic, 1886, recommends a five to ten per cent ointment in the treatment of seborrhœic eczema resulting from alopecia areata, and prefers it to ichthyol or pyrogallic acid.

He mentions as an especial advantage its lack of color and freedom from staining. In psoriasis its action is not so favorable, but for all dry scaly eczemas of the face he recommends it.

On account of the difficulties of diagnosis in skin diseases of the face, he advises that the drug be discontinued the moment it is noticed that no improvement is taking place. In scars or pitting from variola, traumatism, acne, or other cause, and in false keloid he has found it of benefit, but its advantages over ichthyol and other reducing substances lies wholly in the fact that it does not produce discoloration and does not inflame the eyes as does chrysarobin, although under certain circumstances the latter drugs have preference. Dr. Unna declares himself quite convinced that in acute exanthema, and especially in scarlatina and variola, resorcin is destined to play a very important part.

In chronic skin diseases its use must remain limited to external application.

### URTICARIA PIGMENTOSA.

In an article on the various forms of urticaria, Dr. Lazansky (*Prager Med. Wochenschr.*, Apr. 21, 1886) devotes some space to the consideration of urticaria pigmentosa.

The peculiarity of this form of chronic urticaria is that, after the disappearance of the wheals, there remains on the site which they occupied a pigmentation which may persist for a long time. Only seventeen cases, according to La-

zansky, have been recorded of this rare disease, and these have been observed for the most part by English authors. Dr. Morrow reported a case in the *Archives of Dermatology*, January, 1879, and Pick (*Prager Zeitsch. f. Heilk.*, II., 1881) and Lewinski (*Virch. Arch.*, 1882, 3 H.) have written upon the subject. The symptoms and course of urticaria perstans pigmentosa are as follows: The affection appears soon after birth, and is therefore to be looked upon as a congenital affection, or one of early infancy; it continues during several years, and the general health is not materially disturbed. There appear almost without prodromata, light-red roundish spots up to five centimetres in diameter, in which a wheal forms, at first white, but afterwards becoming of an intense red color. The wheal disappears, leaving a red spot, which little by little is changed into a brownish-red or light-yellow pigment stain, or the surrounding redness may disappear, while the wheal remains prominent to flatten down later on, but, in this case as well, pigmentation followed its disappearance. There is only slight itching, pricking, or burning, and consequently the results of scratching are seldom seen. Scaling, suppuration, bullæ, and vesicles are not met with.

The whole body, with exception of the neck and face, or only particular regions may be implicated.

The distinction is made between this form and the ordinary urticaria by the long persistence of the wheals and the remaining pigmentation.

Pick and C. Fox have examined these wheals microscopically, and found small hæmorrhagic foci in the skin tissues surrounded by a small cell infiltration of the connective tissue, the papillæ enlarged and the epidermis unchanged.

In Lewinski's case, the pigment deposits were present up to the patient's 9th year; after this, the wheals disappeared without leaving pigment stains behind. The case reported by the author occurred in a female child at the age of 10 months, and was under his observation for three years.

The wheals, at first of an intense red, became paler in a few hours, disappeared in from twenty-four to thirty-six hours, leaving behind a brown-red macule, which would not wholly disappear under pressure of the finger. During the three years of observation, there were eight attacks, each lasting many weeks, the last occurring in the fall of 1885. At the date of report, the child was strong and well as it had always been, and the skin healthy, except that, scattered over the body, and especially the lower extremities, are found round or oval pigment stains, either confluent or discrete. The face, neck, soles, and palms are free. The spots become reddened by rubbing or warming, and dark or sometimes blue in the cold.

There is no itching. During the past year, the eruption has been less frequent and less severe.

### ABSORPTION OF FATTY SUBSTANCES.

PROF. UNNA has proven that the more a fatty substance absorbs water the more rapidly it is itself absorbed by the skin.

100 parts of Vaseline are found to absorb.....	4	parts of water.
Of Axunge . . . . .	15	" "
Of Cod-liver Oil, 70.....	32	" "
White Wax, 30.....		
Of Linseed Oil, 70.....	48	" "
White Wax, 30.....		
Of Oleic Acid, 70.....	60	" "
White Wax, 30.....		
Of Lanolin . . . . .	105	" "

## Items.

---

### GLYCEROLE FOR CUTANEOUS PRURITUS.—

R̄ Acidi Carbolic.	.....gtts. xv.
Sodii Biboratis.	..... 3 grams,
Glycerinæ.	.....30 “

M. Apply with a brush over the pruriginous surfaces.—*Le Concours Médical*, No. 18, 1886.

**COCAINE IN HERPES ZOSTER.**—In a case of herpes zoster, occurring in a child of 7 years, in which all ordinary remedies failed to give relief, Weisenberg applied a five-per-cent solution of cocaine every two hours over the seat of the eruption. That night the child slept quietly, without being awakened every five minutes, as during the previous night, by the burning pain and itching. The following day the pain had ceased, but there remained an itching, which was attributed to the astringent action of the cocaine, which found in the ruptured bullæ an easy mode of penetration to the Malpighian layer. The itching soon disappeared, and at the end of twelve days no trace of the eruption remained. The cocaine, in addition to its anæsthetic properties, was thought to have hastened cicatrization.—*Allg. Med. Central Zeitung*.

### SOLUTION FOR VULVAR SYPHILIDES.—

Hydrate of Chloral	..... 5 grams.
Tinct. Eucalypti	..... 10 “
Aq. destillat.	.....100 “

M. f. sol. for the dressing of mucous patches and ulcerous syphilides.—*Jour. de Méd. de Paris*, June 13, 1886.

**COCAINE AND BORIC ACID IN GONORRHŒA.**—M. Bedoin employs bougies containing ten to twenty centigrams of cocaine in the early stage of gonorrhœa. They were found to have an excellent effect in calming erections. At a later stage he employs bougies containing twenty to twenty-five centigrams of boric acid. The duration of the treatment was from ten to twenty-three days.—*Le Progrès Médical*, June 12, 1886.

**APPLICATION FOR WARTS.**—The following formula, a modification of that recommended by M. Vigier for corns, is largely used by Vidal:

R̄ Acid. Salicylici.	.....1 gram.
Alcohol, 90°	.....1 “
Ether	.....2½ grams
Collodion	.....5 “

M. The solution should be painted over the affected surface each day.—*Jour. de Méd. et de Chirurg.*, June, 1886.

### TREATMENT OF ERYTHEMATOUS LUPUS BY THE APPLICATION OF A MIXTURE OF VINEGAR AND YELLOW OF AN EGG.

—Dr. Brocq (*Journal de Médecine de Paris*) calls attention to a practical, convenient, and cheap means of treating erythematous lupus, which the author declares is not inferior in efficacy to any other therapeutic method employed in this disease. Equal parts of the yellow of a fresh egg and ordinary vinegar well beaten up together, and allowed to macerate for twenty-four hours, may be applied in two or more layers over the affected surface. Or a paste made of the yellow of a hard-boiled egg, triturated with vinegar, macerated for several hours, and spread upon a piece of flannel, is applied every night, care being taken that it shall extend beyond the borders of the diseased patch, and the next morning it is to be washed off with black soap.

This procedure does not occasion pain causes only a slight inflammation, is well tolerated by patients, and is followed by a notable improvement. In addition, it does not demand, like scarification or the application of pyroligneous and pyrogallic acids, the surveillance and constant intervention of the physicians. —*Gazette Médicale de Nantes*, No. 4, 1886.

**WHITE CLAY IN EPIDIDYMITIS.**—According to the *Journal de Méd. de Paris*, March 28, 1886, white clay, such as is used by sculptors, has been used in Russia with much success in many cases of gonorrhoeal epididymitis.

It is made into a soft mass, spread upon a square piece of linen cloth, and applied to the whole scrotum.

Boskine attributes the therapeutic effect of the *argile*, as it is called, to its refrigerating and metallo-therapeutic properties.

**AMERICAN DERMATOLOGICAL ASSOCIATION.**—The following papers are announced to be read at the Tenth Annual Meeting, to be held at the Indian Harbor Hotel, Greenwich, Conn., August 25, 26, and 27, 1886. Address by the President, Dr. Edward Wigglesworth.—1. Report of a Case of Lymphadenoma (Mycosis Fongoïde), and Autopsy, by Dr. G. H. Fox.—2. Note Relative to the Bullous Eruption Occurring after Ingestion of Iodine Compounds, by Dr. J. N. Hyde.—3. Erythema Syphiliticum, by Dr. E. B. Bronson.—4. "Rötheln," by Dr. I. E. Atkinson.—5. Precocious Gummata, by Dr. R. W. Taylor.—6. Clinical Notes on Scabies, by Dr. F. B. Greenough.—7. Clinical Observations regarding the Value of Resorcin, Ichthyol, and Lanolin in Cutaneous Diseases, by Dr. H. W. Stelwagon.—8. Trophoneurosis of the Skin, by Dr. G. H. Tilden.—9. Native Plants Injurious to the Skin, by Dr. J. C. White.—10. Erythema Multiforme and its Allied Affections, by Dr. A. Van Harlingen.—11. A Few Additional Notes on Psoriasis, by Dr. F. B. Greenough.—12. Report of a Case of Exfoliative Dermatitis, by Dr. W. A. Hardaway.—13. A Clinical Study of Scleroderma, by Dr. G. E. Graham.—14. A Case of Carcinoma Cutis, by Dr. L. N. Denslow.—15. Keratosis Follicularis, by Dr. P. A. Morrow.—16. Surgical and Obstetrical Scarlatina, by Dr. I. E. Atkinson.—17. Notes on Drugs, by Dr. H. G. Piffard.—18. Two Cases of Dermatitis Herpetiformis, by Dr. A. Van Harlingen.—19. Remarks and Queries on, and as to Relative Frequency of, Moles and their Pathological Changes on the Face and Head, by Dr. S. Sherwell.—20. An Unusual Form of Tuberculosis of the Skin, by Dr. G. H. Tilden.

G. H. TILDEN, M.D., *Secretary*.

EDWARD WIGGLESWORTH, M.D., *President*.



JOURNAL  
OF  
CUTANEOUS AND VENEREAL DISEASES.

---

---

VOL. IV.

SEPTEMBER, 1886.

No. 9.

---

---

Original Communications.

---

KERATOSIS FOLLICULARIS, ASSOCIATED WITH FISSURING OF THE  
TONGUE AND LEUKOPLAKIA BUCCALIS.<sup>1</sup>

BY

PRINCE A. MORROW, A.M., M.D.,

Clinical Professor of Venereal Diseases, University of the City of New York; Surgeon to Charity Hospital.

THE comparative rarity of this form of follicular disorder, its unusual development, and its association with peculiar mucous membrane changes in a case which recently came under my observation, have led me to believe that a report of its more characteristic clinical features may not prove uninteresting to the members of this Association.

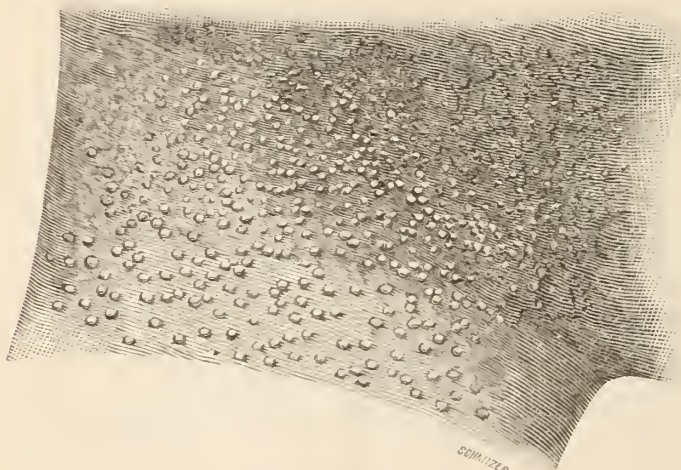
The patient, Chas. Olsen, æt. 21, a sailor by occupation, presented himself at my class at the Bellevue Out-Door Poor in December, 1885, with the following history:

About five years ago, soon after beginning his seafaring life, he observed a number of blackish protruding points upon the backs of his hands, some of which he occasionally squeezed out. Soon afterward, he observed the same condition of the skin of the neck, arms, and other portions of the body. This peculiar condition has continued ever since, with a very noticeable improvement in the intervals of his voyages, when he is on land, and a marked aggravation when he is at sea.

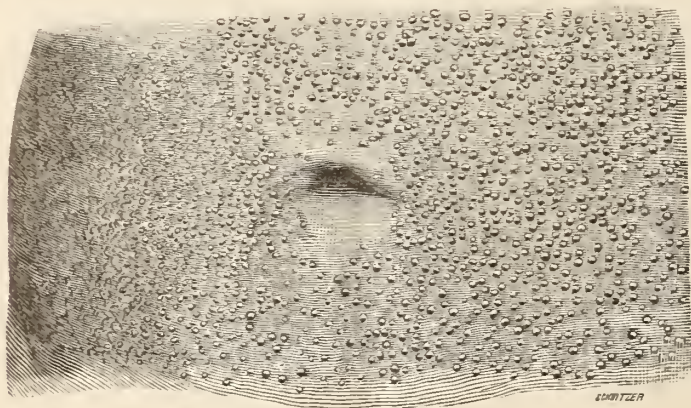
When the patient was stripped for examination, there was observed a

<sup>1</sup> Read at the Tenth Annual Meeting of the American Dermatological Association.

grayish or brownish discoloration of the surface, the pigmentation being most marked upon the abdomen, over the deltoid regions, and the outer aspect of the thighs. Upon passing the hand over the surface, instead of the soft, supple feel of normal skin, there was experienced a harsh,



rough sensation, comparable to that communicated by a calf's tongue. The entire surface of the body, with the exception of the face, palms, and soles, was found to be the seat of follicular disorder, the specific characters of which may thus be described: The ducts of the sebaceous



glands project above the niveau, and are occupied by round or comedo-like substances, grayish or dark in color, some of which protrude in the shape of spinous prolongations, more or less prominent. Many of these spinous projections are one-quarter to one-half inch in length. They

are longer and more abundantly present over the back of the neck, the abdomen, posterior surfaces of arms, thighs, and legs. From many of the follicles, especially over the abdomen, small white hairs protrude.

The comedos, when pressed out, present a grayish, horny, somewhat glistening appearance; they are hard and perfectly dry, and, when thrown upon a sheet of paper, rattle like dried peas. If the process of extrusion was carefully conducted, the hard, more compact part of the comedo was found to be continuous with a stringy, adhesive substance, which dipped deeply down into the follicle, and which could be drawn out some distance. After expression of the contents of the follicles, the ducts still remained dilated and projecting. I removed quite a number of the comedos from a limited area of skin, and the patulous orifices were quite suggestive of the punched up holes of a nutmeg grater. In the photographs of a portion of the neck and the abdomen from which the illustrations are made, the dilated and projecting excretory ducts are admirably shown. None of the follicles show evidences of irritative or suppurative action. No matter how large the comedos, or how long persistent, their presence does not occasion the slightest inflammatory reaction.

Upon the anterior surface of left leg just below the knee, there were five or six small, rounded, depressed cicatrices; on the right leg, there were two or three similar lesions of which the patient could give no account. Over the popliteal spaces of both legs there was a number of dry crusts or scabs which were presumably the result of wounding the skin in scratching, although the patient was quite positive that he never experienced an itching sensation on any part of the body.

Upon examination of the mouth, the mucous membrane over soft palate and roof of the mouth was seen to be studded with innumerable minute brownish spots, apparently indented or depressed, rather than elevated, although to the touch the surface feels perfectly smooth.

The tongue was found to be large, somewhat thickened and flabby, and rough to the touch. The surface was white and pasty, and deeply fissured, the fissures extending down into the submucous tissues. Some of them were veritable clefts, one-eighth to one-quarter of an inch in depth, presenting a certain branched arrangement. The buccal mucous membrane presented an opaline or bluish-white appearance, is thickened and raised in many places, forming distinct plaques which are superficially fissured. This leucomatous condition is especially noticeable at the commissures of the lips, and extending backward along the line formed by the junction of the teeth when closed.

The patient states that his tongue has been "white and a little sore" ever since he can remember. The absence of irritation or marked sensitiveness of the fissured organ was quite a noticeable feature. He suffers

no pain or inconvenience, except when using condiments, especially salty food.

He also has a conjunctivitis and a slight kerato-iritis, for which he is being treated at the Eye and Ear Infirmary. Their possible syphilitic origin was suspected, but the history would seem to negative this assumption. He states that he never had a venereal disease until a little over a year ago (in November, 1884), when ashore in Philadelphia, he stayed with a woman. Before his vessel reached Boston, four days later, he observed upon his penis a small sore, which healed up without treatment in the course of a week or two. He has never had any eruption or other evidence of the disease.

The suspected specific nature of the buccal leucoplakia and fissuring of the tongue was also disproved by the fact of their development several years previous to the occurrence of any venereal disease. Their association with the peculiar changes in the follicular apparatus of the skin must be regarded in the light of an accidental complication, since, irrespective of the patient's history, the objective appearances presented by the tongue and buccal mucous membrane were entirely dissimilar to the ordinary manifestations of the syphilitic diathesis.

The most interesting clinical feature of this case was the implication of almost the entire follicular apparatus of the skin in a morbid process which had resulted in a dilatation and projection of the excretory ducts, and the presence of comedo-like plugs, which were altered in character and exaggerated in development.

Examination of the contents of the follicles showed a deficiency of fatty matter, and a marked increase in the corneous elements. They were dry, hard, and of horny consistence.

The cause of the cornification must be sought for in some structural peculiarity or lesion of the sebaceous glands, permitting a premature exfoliation of the epithelium before fatty transformation of the cells was complete. Associated with this vitiated secretion, there was probably an atony of the glands, or deficiency of excretory power, resulting in long retention of the sebaceous matter in the excretory ducts. Owing to this obstruction, desiccation and solidification of the mass took place, and in the process of excretion, the hard, cornified contents were pushed up above the surface of the skin in the form of elongated sebaceous plugs, which preserved the exact shape or mould of the ducts.

The sebaceous plugs were evidently of the nature of comedos differing from ordinary comedos in their consistency, their exaggerated development, and their generalization over parts of the body where comedos are not commonly met with.

This form of follicular disorder also presents certain analogies with a variety of sebaceous disease characterized by a copious secretion of seba-



aceous matter which concretes upon the surface, forming an incrustation of dry hard scales. In both, the excretory ducts are dilated and patent, in both there is a vitiated secretion, which assumes a hard horny consistence. It is to be differentiated from ichthyosis sebacea by the fact that in the former there is an atony of the glands with deficient secretion, in the latter there is a hyperactivity of the glands with excessive secretion. In one case keratofication takes place within the interior of the canal, in the other it is secondary, the hard cornified character of the incrustation being due to desiccation of the sebaceous fluid after its escape from the excretory ducts.

So far as I have been able to ascertain, the literature of this dermatosis is comparatively limited and somewhat confusing, since there seems to be no uniformity in the nomenclature employed by different authorities. Under the term *acné sebacée cornée*, Guibout<sup>1</sup> describes a disorder of the sebaceous follicles, the clinical features of which closely correspond to those presented by my own case. He says: "In this form the sebaceous matter, secreted in great abundance, is retained in the excretory ducts of the sebaceous glands, it there hardens and takes on the consistence of horn. The rounded cylindrical or thread-like form is given to it by the calibre of the excretory canal, in the interior of which it had been retained, hardened, and as if moulded. In elevating itself above the niveau of the skin in the form of projections more or less prominent, the sebaceous matter forms so many hard prickly and horny points which give to the hand passed over the surface the dry pricking sensation which it experiences from the skin of a reptile or fish."

Evidently Guibout had never met with a case in which the follicula, disorder was so generalized as in the one which came under my observation, since he mentions as one of the differential features of *acné sebacée cornée* that it is scarcely ever met with except upon the brow, cheeks, and nose. In my case, it is worthy of note that these parts were entirely exempt from any manifestation of the disease. The objection to his designation is that the employment of the term *acne* is by modern authorities restricted to sebaceous disorders in which an inflammatory element is present.

In the volume on "Diseases of the Skin" (Ziemssen's Cyclopedia), Lesser refers to this disease, which he says is exceedingly rare, under the name of *ichthyosis follicularis*. In order that there may be no question of its identity with the disease under consideration, I quote his description of what he characterizes as an exquisite example of this variety of ichthyosis.

The patient was a boy 6 years of age. "Over the extensor surfaces of the extremities, most markedly on the wrist and ankle, besides on the

<sup>1</sup> "Nouv. Leçons Cliniques sur les Maladies de la Peau," Paris, 1879.

face over the brow, nose, and auricular edges, thin compact scaly columns, even as long as a millimetre, whitish or grayish in color, are seen projecting from a large number of follicles. The flexor surfaces of the trunk are very much less affected, and the palms and soles are entirely free. On the scalp which centrally has a few isolated hairs and peripherally a scanty growth, these epidermal spines may be seen projecting from a number of hair follicles. The eyebrows are entirely wanting, and in this region the affection is very marked. Passing the finger over the diseased parts produces a sensation like that caused by the prickly surface of a rose leaf."

The use of the term *ichthyosis* is objectionable, since it suggests a disease which is entirely different in its nature, its mode of development and its objective symptoms. *Ichthyosis* is recognized as a congenital malformation of the skin, characterized by an anomalous and devious development of the epidermis, which is modified in its arrangement and altered in character; the disease under consideration consists essentially in an affection of the sebaceous glands, for while the hair glands are to a certain extent implicated in the morbid process, the former play the principal part in the production of the peculiar phenomena.

I have selected the term *keratosis follicularis* as more correctly expressing the pathological condition present, as well as indicating the anatomical seat of the disorder. If the morbid changes were limited to the sebaceous glands, *keratosis sebacea* would perhaps cover the condition, but since the annex glands of the hair are also involved, the more comprehensive qualifying adjective, which includes both groups of glands, is to be preferred.

Appended will be found the results of the microscopical examination of sections of the lesions, which were made by my friend, Dr. A. R. Robinson.

*Anatomy.*—A single, markedly elevated and well-developed lesion from the abdomen, and two closely situated and smaller lesions from the back were removed, and hardened by putting them first in Miller's liquid and afterwards in alcohol.

In Fig. 1 is shown, under a low power, a section through the central part of the single lesion. The corneous layer is thicker than normal, the rete is unchanged, and the corium presents nothing abnormal except a slight dilatation of some of the blood-vessels in the immediate neighborhood of the papule. The lesion (papule) itself presented the following characters: The part above the general surface (*d*) consisted of epithelial cells in various stages of degeneration, although the majority resembled those of the upper corneous layer of the skin or the epithelial cells of the funnel-shaped orifice of a hair follicle. The remainder of the papule—the part beneath the general surface—consisted of fatty and corneous

degenerated epithelium, epithelial and fatty débris, and portions of hair shafts, all lying in a greatly distended sebaceous gland. The outer layers of epithelial cells of the sebaceous gland were flattened against the basement membrane, and the more internal layers were also flattened and showed no signs of undergoing the normal fatty transformation.

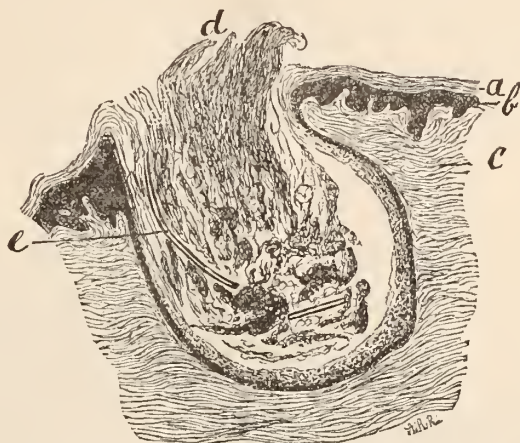


FIG. 1.—Section of a solitary well-developed papule. *a*, corneous layer; *b*, rete layer; *c*, corium; *d*, central elevated part of lesion; *e*, fragment of hair-shaft.

That the lesion consisted in changes occurring principally in the sebaceous gland was shown by the nature of the contents of the papule, its situation or limitation to the upper part of the corium; the hair-follicle extending much deeper than the lesion, and by the globular shape. If it was a lesion specially affecting the hair-follicle, it would have extended to the subcutaneous tissue, it would not have had such a rounded form, and the contents would not have consisted of so many broken-down epithelial cells. It resembled the appearances found in many comedones, except that I have never seen so many epithelial cells in the sebaceous plug as is present in this case; that is, in this lesion there is a keratosis combined with obstruction and dilatation of the gland.

In Fig. 2, which represents a section from the two closely situated and smaller lesions, the corneous layer is seen to be much thickened in the neighborhood of hair-follicles, and especially in the follicle area. At *f* the epithelial cells are shown in greatly increased numbers. This portion of the section corresponds to the funnel-shaped part of the hair-follicle, hence the occurrence of epithelial cells so low down in the section.

At a distance from the papule the corneous layer was normal. The rete was normal except that there was a marked increase in the amount of pigment over the normal in the lower rows of rete cells. This increase



is represented in the drawing. The corium was normal, except that the blood-vessels were somewhat dilated, and there were quite a number of round cells in the perivascular area; signs of slight inflammatory changes, due probably to irritation from pressure exercised by the papules. The apex of one of the papules corresponds to *d*, and is shown to be in a hair-shaft area, as the hair (*e*) passes through the centre of the elevated mass. As in the previous lesion, the elevated part consists almost entirely of epithelial cells, with their origin in this case from the corneous layer and corresponding part of the hair-follicle orifice. Within the skin

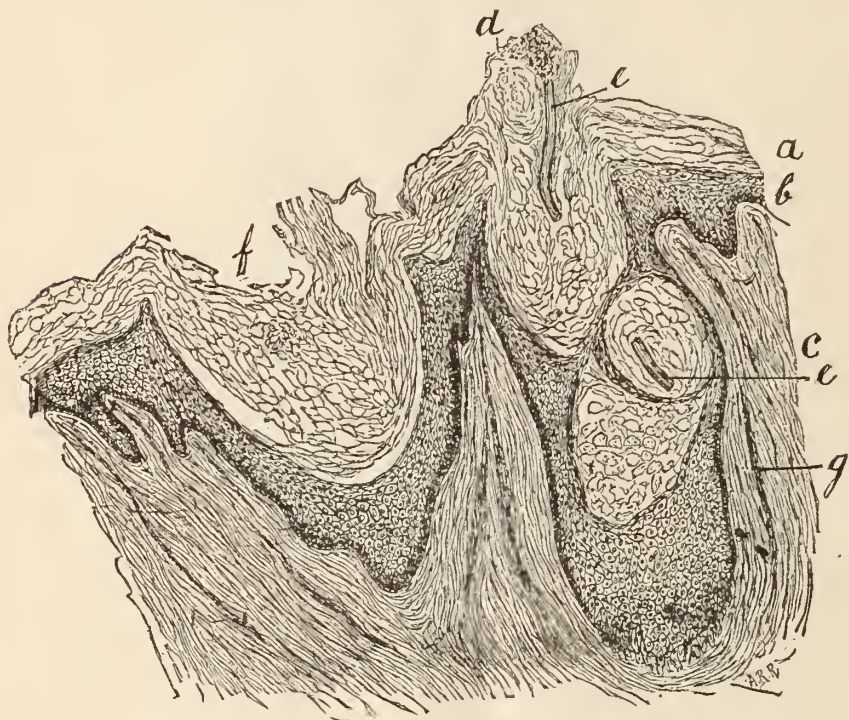


FIG. 2.—Section of two small papules. *a*, corneous layer; *b*, rete mucosum; *c*, corium; *d*, apex of papule; *e*, hair shaft; *f*, hair-follicle exit area; *g*, blood-vessels.

the papule is made up of similar epithelial cells, and lower down of cells from the sebaceous gland. In this drawing the sebaceous gland may be considered to begin about on a level with *e*.

This drawing, which represents a more recent lesion than Fig. 1, shows the pathological condition to be essentially one affecting the corneous layer and similar cells, and consists in a hyperplasia of that structure. The changes in the sebaceous glands corresponding to the comedo condition are probably secondary, and consequently the affection might be



called a keratosis affecting the follicles. I believe many of the lesions of ordinary comedo arise in the same manner, that is, primarily as a keratosis, causing obstruction to the expulsion of the sebaceous gland contents.

## DISEASES OF THE SKIN IN THE SUBJECTS OF GOUT. A REPORT OF THREE CASES; WITH REMARKS.<sup>1</sup>

BY

WILLIAM T. CORLETT, M.D., L.R.C.P. London,

Professor of Diseases of the Skin in the Medical Department of the University of Wooster, Cleveland, O.

CASE I.—Mary B., aged 62, a native of Ireland, married, was admitted an out-patient at the Clinic for Skin Diseases November 11, 1883. The family history shows her immediate ancestors to have been free from gout, rheumatism, or any protracted illness. A brother of the patient died two years ago with symptoms identical with that of the present case. At the age of 27, she came to America, having previously enjoyed robust health; soon after her arrival, she suffered from intermittent fever, which continued three years. After this she had good health until the menopause at the age of 46, and bore five children, four of whom are now living. At this time she suffered from what was called rheumatism; she said she was confined to her bed with an inflammation of the small joints, which first appeared in the ball of the great toe; paroxysms of pain came on at night, at which time the weight of the bed clothing could not be borne; these paroxysms have recurred from time to time since. At the age of 55, an eruption broke out on the lower part of the legs, in appearance similar to that which now covers the forearms, as shown in the plate; in the course of a twelvemonth this resulted in two ulcers. I could obtain no history of syphilis, although she had been under syphilitic treatment.

On admission, she complained of pain in her feet and difficulty in moving her fingers. The pain in her feet prevented sleep, not in recurring paroxysms, as at first, but continuously; the parts could be handled without special discomfort. The face had a puffy appearance, best marked in the lower lids, and the skin was of a pale, waxen hue. The forearms and legs were covered with an eruption of a dark-reddish color, slightly sealy, moist only when scratched, itching moderate. On the left leg are two irregular shaped ulcers as herein shown, on the right there are three cicatrices the size of a quarter of a dollar. The veins of the leg are of normal size. The joints of the foot are ankylosed, those of the hand markedly stiffened; they are enlarged by bony concretions, especially prominent at the metatarso-phalangeal joint of the great toe. The urine at the time of passing was acid; specific gravity, average in six days, 1,028, slightly albuminous; passed a small quantity; bowels gener-

<sup>1</sup> Read before the Ohio State Medical Society, June 4, 1886.

ally open; appetite poor; tongue furred. Serum from a blister, treated with acetic acid and evaporated, showed uric-acid crystals adhering to a cotton fibre which had been immersed in the liquid. She said since coming to this country beer had not agreed with her, and ale made her chilly; she had never used beer or spirits to any extent. She made use of meat twice a day.

The treatment adopted was wine of colchicum, ten minims; liquor of potassium, ten minims; and infusion of gentian twenty minutes after each meal. She was directed to keep the legs elevated and the ulcers covered with mineral earth. At the end of a fortnight she returned, the eruption had improved, and the ulcers gave less inconvenience. On account of its purgative effect, the colchicum was discontinued, and, considering her advanced age and more advanced state of structural dis-



solution, soothing and tonic measures alone were employed. At the present writing, she is free from the eruption, and the ulcers have diminished fully one-half; in other respects, her condition remains about the same.

CASE II.—Sarah B., aged 21, single, daughter of the patient preceding, applied for treatment at the College Clinic for Skin Diseases October 12, 1885. She had enjoyed robust health up to the age of 18, although her menstruation had been irregular since it first appeared, at the age of 14. Three years ago she had a reddish eruption on her forearms and legs, very itchy and moist; this had disappeared and returned several times. She had suffered for one year or two with muscular rheumatism. On admission, she appeared well nourished, and was well developed. She complained of an eruption which was very itchy. It was distributed discretely over the body; the flexor and extensor surfaces

were equally affected, likewise the exposed and protected parts. It was of a dark-reddish color, slightly scaly, more so on the trunk than on the extremities, whereas on the latter it was more moist. It seemed a hybrid between psoriasis and eczema. Her urine was acid at different times, and the specific gravity averaged 1,018. Upon standing, it threw down a free deposit of urates; it contained also uric acid, urea, and oxalate of lime; she passed a free quantity. Serum from a blister tested with uric acid gave a negative result; the saliva was acid; appetite good; bowels constipated.

She was given blue mass, four grains, to be repeated at the end of a week, and Rochelle salts in hot water before breakfast. For local treatment, tar ointment was employed. She made a speedy recovery, and up to the present writing remains well.

CASE III.—John M., aged 55, married, an Englishman by birth, was admitted into St. Elexis Hospital February 4, 1886. The family history as related by the patient is good. John M. set out in life as a sailor, which vocation he followed until 30 years of age, when he had the scurvy, and was confined in a hospital in Liverpool, whereupon he quit the high seas, and adopted the painter's craft, which vocation he has followed to the present time. He is very susceptible to the influence of lead, and has had lead colic several times. At the age of 33, he had an eruption which covered the entire body; it appeared quite suddenly, was very scaly, and the itching annoyed him at night. This attack left him in a few weeks, but similar attacks have returned with increasing frequency, and of late they have been almost continuous. When admitted, he complained of general debility, sciatic pains, and an eruption which was moderately itchy. The eruption covered the entire surface of the body, the epidermis came off in large flakes the size of the palm, the skin underlying was moist. His appearance was that of advanced senility; anæmic with arcus senilis, muscular tremors, and an atheromatous condition of the arteries. Appetite poor, and bowels habitually constipated. Urine scanty; the measurement for three days gave twelve ounces *per diem*, of high color, acid reaction, specific gravity 1,030, albuminous; upon standing, deposited the urates abundantly; oxalate of lime and granular casts were also present. Serum from a blister contained uric-acid crystals.

The patient was given a diet of milk, a small quantity of stale bread, green vegetables *ad libitum*, and fresh mutton or beef twice a day, with lemon juice in lieu of tea or coffee. Alkalies and vegetable bitters were given as a medicament a short time after meals, and Rochelle salts in hot water upon rising in the morning. Locally, alkaline baths, followed with tar ointment. With this, he is improving, and has resumed work. The case is still under observation.

In selecting these cases the primary object is to illustrate certain salient features in the genesis of gout as a basis for considering the cutaneous diseases arising therefrom, this would be unnecessary were it not that many competent observers do not recognize the influence of the gouty state in the evolution of diseases of the skin; secondly, to point out the distinguishing features of the lesions themselves; and finally, to outline the treatment best suited for them.

Without discussing the etiology of gout, which would be foreign to the scope of this paper, we shall assume the condition to arise from an imperfect oxidation of the albuminoid substances of the food which enter the blood in the form of uric acid, lactic acid, oxalic acid, kreatin, and kreatinin. These substances represent the stages or by-products of assimilation and disassimilation, the conversion of food into tissue and again of tissue into excrement, which is so aptly expressed by Piffard.<sup>1</sup> Further, this suboxidation depends for the most part on derangements of the liver<sup>2</sup> and spleen;<sup>3</sup> while elimination takes place through the kidneys, bowels, skin, and pulmonary mucous membrane. From this we may readily conclude, *a priori*, that these improperly prepared and insoluble products will, if continued, induce in these several channels of excretion pathological states, of which those of the skin are herein considered. In the history of the first case, malarial influence seems to have been the starting-point of a succeeding train of woes, but whether or not malarial poisoning, with its well-known influence on the liver and spleen, should be regarded as the *fons et origo* of the subsequent lithæmia, opinions may differ. Whatever the cause, the diathesis seems to have been acquired.

In the second case we have the outburst of a transmitted diathesis: the patient, the youngest of five children, born when the maternal organization had already acquired the taint from which both mother and daughter now suffer. It appeared, too, in early life, when functional activity is at its height; when the system, unencumbered by inherited vice, would surmount extraneous influences under which it now gives way.

The third case is representative of the class spoken of by Roosc,<sup>4</sup> of which he says "the injection of lead into the system produces an excess of uric acid in the blood, and the subjects of gout are easily poisoned by lead. Here we have poisoning preceded by the scurvy, followed by a cutaneous inflammation, which recurs from time to time, and which is associated with an excess of uric acid in the blood, three conditions closely allied, if not dependent upon the same morbid influence."<sup>5</sup> But the practical question which interests us to-day is, how are the eruptions which arise from lithæmia to be known, what are their distinguishing points, what are their salient features? Murchison says, anatomically there is nothing to distinguish these eruptions from those due to other constitutional states.<sup>6</sup> Tilbury Fox refers to eczema as the progeny of

<sup>1</sup> "Materia Med. and Ther. of Skin Diseases," 1881, page 131.

<sup>2</sup> Murchison, "Functional Derangements of the Liver," 1879.

<sup>3</sup> Parks, *Lancet*, 1871, vol. I., page 467.

<sup>4</sup> "Gout and its Relation to Diseases of the Liver and Kidneys," 1885.

<sup>5</sup> Ralfe, "Clinical Chemistry," 1883, page 290.

<sup>6</sup> "Functional Derangements of the Liver," 1879, page 150.



gout; and Liveing described gouty psoriasis. With due respect, I venture to be of opinion that objectively, if not anatomically, these eruptions have peculiarities which may be best described as a hybrid between eczema and psoriasis, retaining points of semblance to each, yet so blended as to form a type which differs from them both. Of the lithæmic eruptions which have come under my notice, the following features were most noteworthy: First. They were scaly; the scales were not adherent nor heaped up, neither were they of a silvery color, as in psoriasis; when detached they left an oozing surface. Second. The color was reddish and closely resembled a syphilide. Third. There was a tendency to a symmetrical distribution. Fourth. They were met with in adults usually after forty-five, except when inherited. Fifth. They were accompanied by other evidences of lithæmia. Sixth. They are prone to return.

Let me conclude by giving a few suggestions as to the treatment which has proved most useful in this class of skin diseases. The diet is of primary import and does not differ from that employed in the treatment of gout. In this there can be no fixed rules; some require more than their accustomed fare, while others must be curtailed to a Lenten simplicity. All have special idiosyncrasies which are imperative. The things generally to be interdicted are: rhubarb, strawberries, apples, pickles, sugar and acids, except in moderation; eggs, lobsters, and fats are generally ill borne. Malt liquors, port wine, and champagne should be especially prohibited, and the free use of water should with equal emphasis be encouraged. After this the digestion should receive attention; first, the hygienic laws pertaining thereto should be enforced, and, if necessary, vegetable bitters, pepsin, or pancreatin may be given as indicated. Next in importance to the diet is fresh air and exercise. The special medication embraces the alkalies, colchicum, and in exceptional cases the mineral acids. Of the first, the liquor of potassium, ten to fifteen minims well diluted, taken twenty to thirty minutes after meals, as suggested to the writer by Dr. Liveing, of London, is of benefit in a large number of cases. At times Rochelle salts, Carlsbad salts, or the mineral waters are required; they should be taken before breakfast, the former well diluted in hot water. Again, the lithia salts act best; this has been noted when the eruption was accompanied by muscular rheumatism. My very limited experience with colchicum is not favorable to its use. When benefit was derived it seemed to depend on its purgative effect. Local treatment is of little importance except to mitigate suffering. The alkaline baths, preparations of tar, and ammoniated mercury comprise the means most in vogue and best suited to this end.

## LANOLIN.

BY

D. F. KINNIER, M.D., Randolph, Mass.,

Late Assistant to Dr. T. Colcott Fox, London, Eng.; Memb. Brit. Med. Association.

**L**ANOLIN has been recently introduced to the notice of the medical profession by Dr. Oscar Liebreich, of Berlin.

This substance is obtained from the alkaline water washings of sheep's wool; it is a fatty body consisting of fat acids and cholesterol in varying proportions; these substances are mixed with a certain percentage of water, and a smooth unctuous mass results.

Lanolin is at present being largely used as a basis for ointments both in this country and in Europe, and very encouraging results are reported by many who have used it, but it will be necessary to give it further trial before its proper sphere of usefulness is ascertained.

Since lanolin is rapidly absorbed by the skin, lard or cerate should be added in small proportion, to prevent its too rapid absorption where this effect is not required.

Lanolin can be readily rubbed into the skin without producing any irritation, and hence is very serviceable in dermatitis of delicate skins.

Medicinal substances combined with lanolin are said to be more readily absorbed when applied to the skin than when a different ointment base is used. Lanolin is too sticky a substance to be used alone, and hence Liebreich suggests that some substance be added to make it more pliant.

He has experimented with various substances, as oils, vaseline, paraffin ointment, glycerin, and fat, and of these he has found the fat to be preferable because, unlike the others, it does not interfere with the absorbing properties of the lanolin.

Lanolin is capable of taking up more water than other fatty bodies; it mixes with more than one hundred per cent of water, forming a light-yellow, plastic salve.

Deiterich states that vaseline takes up 4 parts of water, lard 15, benzoinated lard 17, and lanolin 105 parts. Lanolin being a neutral base will not decompose any medicament which may be added to it.

Dr. Liebreich, whose experience with the drug is limited, has nevertheless obtained very promising results from its use; others who have used it speak very highly of it. Dr. Liebreich states that corrosive sublimate salve (1:1,000) made with lanolin, if rubbed into the skin, is so rapidly absorbed that the characteristic metallic taste due to the absorption of the mercury will be noticed in a short time. Lanolin being so rapidly

absorbed by the skin, it is preferable to mix a certain per cent of some fatty substance with it, so that when rubbed into the skin for any length of time it will not leave the skin dry, as would be the case were lanolin alone used.

Dr. Lassar, who has used it in a large number of cases, says that it does not irritate the skin and is recommended in massage. He uses a twenty-five per cent chrysarobin-lanolin ointment in cases of psoriasis with good success, the psoriatic patches quickly disappearing and without causing irritation of the skin.

I will now briefly mention a few cases in illustration of the uses of lanolin.

Mrs. C., aged 30, was seen by me in May last; she said she was subject to psoriasis more or less for the past ten years, the eruption varying in intensity and duration, but in May of the present year the disease suddenly developed into an extensive eruption extending over the face, chest, back, and limbs; it was in fact a typical case of universal psoriasis. The patient was covered with small scaly patches from head to foot. She said that her father, who is about sixty years old, was also troubled with psoriasis, but there has been no appearance of the disease for a long time.

She has three brothers and two sisters, two of the former and one of the latter persons being affected more or less with the same disease, though in a very light form.

The treatment consisted of alkaline baths which were afterwards followed by ointments. To one limb I applied an ointment made up of 30 grains of pyrogallie acid and 15 grains of salicylic acid to the ounce each of lanolin and benzoinated lard.

This ointment caused no irritation, the patient returning in one week with slight improvement.

Thinking that a stronger ointment might be more effective, I added ten grains of the former and five grains of the latter acid and saw my patient again in a few days and found great improvement in the disease, which I attributed to the stronger ointment; this produced a very slight irritation which was readily soothed by a bland application. This ointment was used on the limb of the right side only. Over the rest of the body except the face I used the following ointment (Liebreich):  $\mathcal{R}$  Chrysarobini, partes 20; Adipis, partes 10; Lanolini, partes 80. This ointment produced a marked improvement, so that in one week the portions of the body to which it was applied were greatly improved, and in three weeks the scalliness had entirely disappeared, leaving no trace of the eruption except some brown pigmentary stains, probably due to chrysophanic acid, which entirely disappeared. For the eruption on the face I used:  $\mathcal{R}$  Hydrargyri præcipitati albi, partes 10; Adipis, partes, 10; Lanolini, partes 80. She was given arsenic internally.

Several other cases of psoriasis were treated similar to this case, with like results, the period of treatment being in some cases longer than in the case related.

In the case of a child, aged 13, who had a profuse form of psoriasis

guttata on the arms and legs, I used the following ointment:  $\mathcal{R}$  Naphthol, gr. iij.; Adipis, 3 ij.; Lanolin,  $\mathfrak{z}$  i.

This acted very well, except that it caused a very slight irritation, which was removed by a soothing ointment. Two drops of liquor arsenicalis were given three times a day.

A child 3 years old was brought to me about the middle of May last with an angry outbreak of eczema of the face and forehead. The mother said the child's face was in this condition for about a week before coming to my office. In addition to the facial eczema, the arms were also affected with eczema rubrum, which the mother said appeared after that on the face had been well out; the child's face was in a similar condition when eighteen months old.

Both arms of the child being affected, I thought it a good opportunity to test the efficacy of lanolin.

Accordingly on the right arm I applied, spread on lint, the following ointment:  $\mathcal{R}$  Zinci oxidi, partes 10; Adipis, partes 10; Lanolini, partes 80.

On the left arm I used oxide-of-zinc ointment. The condition of each arm, as regards disease, was similar, so that one arm cannot be considered worse than the other.

I personally attended to this case, and the arm on which the lanolin-zinc ointment was used healed before the left arm on which the zinc ointment was used. Whether this effect was due to the lanolin I am not prepared to say, but certain it is that the lanolin acted quicker in this case than the zinc ointment.

I also used lanolin-zinc ointment on the face, and it healed quicker than a similar case in which I used twenty to forty grains of oleate of zinc to the ounce of vaseline.

In April last, T. M., aged 25, a painter, consulted me on account of a dark discoloration covering the entire back and chest down to a level with the umbilicus. The disease was also present on the arm, extending below the elbow. The amount of desquamation was very slight; a microscopical examination of a few scales scraped from the diseased surface of the trunk revealed the presence of the microsporon furfur, thus proving the disease to be tinea versicolor.

In this case I prescribed an ointment as follows:  $\mathcal{R}$  Sodii hyposulphitis, 3 ij.; Adipis, 3 ij.; Lanolini,  $\mathfrak{z}$  i. This ointment was very effective, removing the disease in a short time.

In the case of a child, 6 years of age, with enlarged glands under the jaw, I prescribed the iodide-of-lead ointment. I saw the case in a week, scarcely any improvement having taken place.

I then prescribed iodine, ten grains to the ounce of lanolin, with a little lard. I saw the child in ten days, and, much to my surprise, found the swelling had almost entirely disappeared. I have used this iodine-lanolin in a few similar cases, with very satisfactory results.

I have used lanolin in several cases of chapped hands and I am very well pleased with its action, a few cases being cured by a single inunction. In this case I think the lanolin alone is preferable to use, as it is rapidly incorporated into the skin. A few minims of oil of lavender added to the lanolin will give it an agreeable odor.



I have also used lanolin in cases of acne, eczema, and ringworm; in a few cases, benefit was derived; in others, no effect other than that produced by other ointments was obtained.

In most of the cases in which I have used lanolin, I have obtained better results than from other ointments. From personal experiments with lanolin I am satisfied that, when rubbed into the skin, it disappears almost immediately. If other fats are rubbed in side by side with lanolin, the skin to which lanolin is applied becomes turgid and less supple than the part to which fats were rubbed in.

Experiments on the skin of the cadaver with cinnabar-lanolin and cinnabar-fat ointments have showed by microscopical examination that the lanolin ointment penetrated deeper than other fats used as an ointment base.

Lassar finds that lanolin is very well tolerated, especially in cases where, from the nature of the disease, the skin is irritable. He recommends it highly as a base for ointments where deep penetration is desired, as in psoriasis, tinea tonsurans, and syphilis.

To produce suppleness of the skin, he mixes it with twenty per cent of vaseline or cosmoline. In the inunction treatment of syphilis, Dr. Lassar considers the lanolin an improvement. Fränkel finds that lanolin preparations, when applied to the mucous membranes, prevent crust-formation and slightly diminish the secretion.

Lassar reports favorable results from the use of lanolin in eczema, impetigo contagiosa, and pityriasis versicolor.

A very obstinate case of the last-named disease was quickly relieved with three inunctions of an ointment composed of: Lanolini, partes 88; Sulph. præcip., partes 10; Acidi salicylici, partes 2. In chronic cases of scabies and sycosis, he recommends the following ointment as useful: R̄ Naphthol, 5 to 10 parts; Saponis viridis, cretæ albi, sulphur. præcipitati, lanolini, āā 25 parts. Ihle, of Leipzig, recommends a five to ten per cent resorcin-lanolin salve as a good application in cases of sycosis.

Further experiments are necessary before the value of lanolin can be thoroughly ascertained.

---

### ELEPHANTIASIS ARABUM IN CHILDREN.

ACCORDING to the *Revue Mensuelle des Maladies de l'enfance*, March, 1886, Dr. Moncorvo has met with elephantiasis arabum in young children. The author cites a series of interesting personal observations which would go to show that, contrary to the generally accepted belief, this disease is met with in quite young persons, and is not confined to tropical countries, but is observed as well in the temperate climes of Europe.

## LATENT SYPHILIS—A CASE.

BY

E. R. PALMER, M.D.,

Prof. of Physiology and Physical Diagnosis, University of Louisville.

IN April, 1883, A. B., aged 22, blonde, a commercial traveller, contracted three sores on the mucoid surface of the prepuce. They were shown to several doctors in different towns, cauterized each time, and each time pronounced non-infecting sores. On July 17 he consulted me. The three sores had coalesced, were suppurating freely, and notwithstanding past treatment were not indurated. A guarded prognosis was given, the sores treated with cotton dressing and diluted Labarraque's solution, and in a few days the patient discharged well, with the injunction to watch himself carefully, and to report to me from time to time. No internal treatment was given, and though examined frequently for the next six months, no constitutional evidences were manifested.

The following spring (1884), the patient presented to me with gonorrhœa. The case proved obstinate, degenerated into gleet, and was under treatment first by injections, and afterwards by steel sounds all summer. July 20 he called my attention to two oval purplish blotches, each about the size of a watermelon seed, on the inside of the left leg. Careful inspection failed to discover any other cutaneous lesion or any enlargement of lymphatic glands. With doubt as to the nature of the eruption freely expressed, he was given one-fifth grain of protiodide of mercury pills—one three times daily for a month—when, the blotches having wholly disappeared, and no new one put forth, we discontinued the mercury, and we addressed ourselves to curing the gleet, at the same time watching for further manifestations of the syphilis (?). He was discharged in the fall, cured of his stricture. During 1885 he consulted me twice, February 25 and June 29, each time for a non-specific trouble. On inspection at these calls he showed no sign of syphilis. In the fall (1885), he consulted me as to the advisability of his getting married. Again I examined him with negative results, and on being further assured that it was nearly nine months since he had had illicit intercourse, I gave my sanction, and he was married in December to a beautiful and highly accomplished young woman.

Two months afterwards he came to my office with an abrasion on his foreskin. He stated that a few nights previously he had torn both himself and his wife while having intercourse. The sore he exhibited ap-

peared wholly benign, and on his assuring me that it was now some twelve months since he had gone astray, I gave him a little vaseline locally, and dismissed him. Four months afterwards he came to me exceedingly depressed, with the statement that his wife's physician had just told him that she had syphilis. On inquiry, I learned that the lesion on his penis had healed in a few days, but that shortly afterwards a "small lump appeared at its former site, that he again used the vaseline and the lump went away." Physical examination showed left mastoid gland and left epitrochlear very slightly enlarged, nothing else.

The history given of the wife's case was as follows:

About two months after the night of the accident, she discovered herself to be sore at the point of previous laceration, which had long since healed and been forgotten. Six weeks later a papular eruption appeared, and now, four months after infection, she is profoundly syphilitic, though improving rapidly on *Otis' pil. duplex*. Her case was placed under my care by her physician, its gravity being increased by the fact of her being four months pregnant. Examination of the vulva showed a very small *ostium vaginæ* with a discolored oval cicatrix at the base, external, of the right labium minus. The abrasion on the husband occurred on the left side of the foreskin, and to complete the history of the infection, I will state that the penis in the case is an unduly large one.

Both husband and wife have been known to me since childhood. He the embodiment of truthfulness, she of maidenly innocence and purity. Deceit, a false or imperfect history of the case are out of the question.

Here, then, is a case of syphilis latent for three years, and that latency not due to what Mr. Hutchinson is pleased to call the antidotal influence of mercury or to any treatment whatever. Here, also, is a case instructive from another standpoint, namely, that but for the accidental proof of direct maternal infection, it would go to swell the list of cases by which is supported the claim that in some occult but frequent way the act of impregnation becomes, or is, an act as well of syphilization.

LOUISVILLE, KY.

---

### SYPHILIS OF THE PLACENTA.

1. THE existence of placental lesions in the course of syphilis is undeniable, but they are by no means constant.

2. In a certain number of cases, we may detect evidence of hypertrophy of the villosities with fibrous degeneration of the connective stroma and obliteration of the vessels, coincident with certain patches of fatty degeneration.

3. In cases where pregnancy does not come to full term, lesions of the placenta and its membranes may be found, more or less pronounced, accordingly as the delivery has taken place near the regular term.

4. Specific treatment may result in a foetus carried, born at full term and living, in women who have previously had successive abortions.—DR. ARTHUR GASCARD, *Th. de Paris*.

## Correspondence.

---

### TREATMENT OF PRURITUS AND RHUS POISONING.

LOUISVILLE, KY., July 21, 1886.

*Editor of the Journal of Cutaneous and Venereal Diseases.*

In reply to the request of Dr. Sherburne in the July number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, that some of your readers should state their experience in the treatment of pruritus, I desire to say that I have had several patients, of late, suffering with this annoying complaint, and have in each case been able to give relief from the excessive itching by means of the following treatment:

A hot alkaline bath at night, containing four ounces each of carbonate of potash and carbonate of soda to thirty gallons of water, followed by inunctions of the glycerite of starch.

A lotion composed of:  $\mathcal{R}$  Acid. carbolicæ, 3 ss.; glycerinæ,  $\mathfrak{z}$  i.; aq., O.i., was sprayed upon the skin several times during the day, as recommended by Dr. Hardaway in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, April, 1885. After the bottle of the atomizer has been filled with the lotion, five drops of the oil of peppermint is added. It is of especial importance to observe the method of treatment in these cases, rather than the drugs that may be used; the spray has the advantages over other methods of local application in being more cleanly, less troublesome, less irritating to the skin, and giving more speedy relief.

In the treatment of Rhus poisoning, I have obtained the best results from the use of a lotion composed of grindelia robusta, one drachm to four ounces water.

Respectfully yours,

J. CLARK MCGUIRE, M.D.

### TREATMENT OF WINTER ITCH.

MT. PLEASANT, TEXAS, July 22, 1886.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

In the July number of your JOURNAL OF CUTANEOUS AND VENEREAL DISEASES I notice a communication from A. B. Sherburne, concerning a skin affection which has puzzled him somewhat, and asks for some light upon the subject.

While the editor's comment upon it is to my mind satisfactory, I would like to add a few words as regards the therapeutics in said affection. The first acquaintance I made with this skin trouble was in February, 1884, a very cold and damp month. It seemed to take the form of an epidemic. In some instances whole families were troubled with it. It made its appearance in nearly every neighborhood in this section, and is still existing, though not to the same extent as when it made its first appearance; it is quite contagious.

My observation as regards its mode of attack is, that it makes its appearance in the majority of cases upon the arms, forearms, hands, and trunk respectively.

During 1884 I treated twenty-two cases. The first three cases I treated with remedies usually used in scabies, with negative results. I regarded the cutaneous affection up to the third case as due to a parasite. I then became satisfied, upon closer examination, that it was not of parasitic origin, but that it was due



to some climatic influence, and identical with winter itch, such as I had seen in the New England States several years ago.

The remaining nineteen cases I treated upon the assumption that I had no parasite to kill, and succeeded in each case in performing a cure in the course of one or two weeks, and since then I have had no reason to dissolve partnership with the treatment or my diagnosis. Several of my professional brethren still contend with me that it is of "bug origin." I have the patient wash the parts affected with water as hot as he can bear, using carbolic toilet soap or any good toilet soap. After drying, apply the following, by rubbing in well with the hands every night and morning:  $\mathcal{R}$  Potass. iod.,  $\mathfrak{z}$  iv.; Iodi resub., grs. v.; Acid. carb. cryst., grs. xxx.; Aq., fl.  $\mathfrak{z}$  vi. M.

W. H. BLYTHE, M.D.

## A PERSONAL CASE OF PSORIASIS—ILL EFFECTS OF ARSENIC.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

DEAR SIR:—Thinking that the history of a case of psoriasis by one who has had it, and one who has made it something of a study, might be of interest, I send you this account.

About seven years ago, at the age of 14, an eruption appeared upon my head, in patches, resembling dandruff. I was treated by an apothecary, who gave me Fowler's solution. After taking this for some time, the eruption having mostly disappeared, I discontinued the use of the medicine, thinking the rest of the disease would disappear of its own accord. It did not, however, but came back as before. That the barber might not see the disease, I used to begin, about two weeks before I had my hair cut, to take the solution, which would make it partly disappear.

I was also treated by a physician, who gave me ointments; but they did me no good. Four years after its first appearance in my hair I had pneumonia; I was sent South, and within two months a few spots of psoriasis showed themselves on my body.

Nearly a year after this, the eruption having grown worse, I consulted an eminent specialist. He put me on acidum arsenicum in increasing doses, afterwards changing to sodii arsenitis, until I took three-eighths of a grain a day, and external treatment was also employed.

Soon after taking large doses of arsenic, the psoriasis spread rapidly over the body until but little healthy skin remained, some of the patches being three times the size of a silver dollar. The itching was so intense that I could not rest at night. My eyes became so inflamed that I could hardly use them, and my skin ghastly white. The arsenic was certainly producing an effect. At last the congestion of the skin became so great that I could not bathe in salt water and could not use soap, both giving great pain. Finding that I was growing worse, I concluded to try another plan of treatment. I stopped arsenic entirely, and upon advice took no meat, tea, coffee, tobacco, nor stimulants. I used laxatives, and applied externally a solution containing chrysophanic acid. I ate fish, fruit, and vegetables, and endeavored to improve my general health in every way I could.

I left for Europe, and upon my return, three months afterwards, the patches had not decreased in size, but the congestion was much less marked. I then took Rochelle salts before breakfast, and applied externally salicylic and pyrogallie acids. There followed a slight improvement.

About six months ago I began to take Olei morrhue,  $\mathfrak{z}$  i.; Tr. nucis vomicæ,  $\mathfrak{m}$  i., after meals; sometimes a little calomel or Rochelle salts, and once in a

while a diuretic. I exercised a good deal, having until then been kept hard at study, took a cold bath before breakfast, besides doing everything else to improve my general health. I used an ointment of chrysarobin.

That was the turning-point in the disease. I began gradually to get better, until now I am perfectly well. I have read, with interest, the "Clinical Notes on Psoriasis," by Dr. Greenough, and the discussion, as reported in the "Transactions of the American Dermatological Association" at its ninth annual meeting. I perfectly agree with Dr. Hyde that itching may be the most distressing symptom of the disease. I was for months unable to get sufficient rest at night on that account, and the arsenic which I took seemed to aggravate the itching. When I applied anything irritating to the patches, that feeling would give place to the most intense burning.

I also believe, with Dr. Fox, that the location of the patches is of but little value as a diagnostic point; for, in the beginning, I had more patches on my chest and abdomen than on my back, and I have *never* had any *either on my knees or elbows*. And as to the remark of Dr. Fox that "too much stress is laid on the robust health of the patients," although they may seemingly be in the best of health, I am sure, if great care were taken, one might always find some weak point in their constitution.

I believe arsenic is bad where the disease is at all pronounced. It proved so in my case, congesting and drying the skin—the two things which should be expressly avoided. I think also that coffee, tea, meat, and stimulants are bad, for I noticed that, as soon as I stopped the use of these, the congestion of the skin began to decrease. Dr. Heitzman's views regarding the application of local remedies while the disease is acute seem to me good. I applied chrysophanic acid to my left forearm while the disease was yet acute, with the result of making the patches worse. And in regard to pressure or friction, some of the first patches on my body came from my clothes rubbing against me. The pruritus, which was so intense, dates from the time I began to take large doses of arsenic.

Dr. Hardaway ascribes two cases of psoriasis to the *inordinate* use of oatmeal. However that may be, I am sure that oatmeal in *moderate* quantity has done me good. I found that it was easy to digest, and that it acted slightly as a laxative. I can substantiate his views regarding the heredity of psoriasis, my grandfather having had it. Diet, and any aid one can give to digestion are of the utmost importance. I used to drink with my meals, and had a slight indigestion. Now I never drink until two hours afterward, and can digest anything. Although this point may seem of little account to some, I believe it is of the greatest importance. There is one thing to which, I am sure, physicians do not devote enough attention. Persons affected with skin disease are exceedingly sensitive, and their disease is so constantly in their minds that they sometimes become almost monomaniacs. This certainly aggravates the disease. If the physician will have them occupy their minds—and their bodies as well—a great change for the better will usually take place.

My experience with arsenic is perfectly in accord with the propositions which Dr. Fox presented to the N. Y. Derm. Society (see June number, C. AND V. JOURNAL). It increased the congestion of the skin, intensified the pruritus, caused the eruption to spread more rapidly, and was used to the exclusion of other internal remedies.

Regarding lanolin: I used an ointment containing chrysarobin and lard on one side of my body, and chrysarobin and lanolin on the other. My judgment is

in favor of lanolin, as it makes a very smooth ointment, and being more adhesive than lard it does not rub off so soon, and has, consequently, a longer time to be absorbed.

MEDICUS.

## DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

### Topical Applications in Diseases of the Skin.

AN interesting paper with this title, by Dr. H. G. Brooke, appears in the *Medical Chronicle*. After pointing out that a local treatment of skin diseases is gaining ground, the author admits that patients are often prejudiced against it, but says this lack of confidence is largely due to the imperfect way in which the local applications are made by the patients themselves. They are usually provided with a box of ointment, and then left to their own resources, with, frequently, insufficient directions. But if the patient have to undertake dressings on a large scale, there is a great deal of trouble involved, and a serious loss of time to the doctor if he have to undertake the task himself; and any form of treatment which involves much trouble or expense to the patient is pretty sure to be imperfectly carried out or neglected, with discredit to the doctor and dissatisfaction to the patient; hence an easy, inexpensive, and at the same time effective mode of application is a desideratum. For this purpose he praises the salve muslins and gutta-percha plasters of Dr. Unna, but finds that they have one or two drawbacks, the chief one being expense. He therefore devised another method, by having medicaments made up with a very stiff basis of wax, cocoa-butter, and oil, and cast into the form of a stick of cosmetic. This, when rubbed on the skin, is sufficiently soft to leave a complete coating of salve, and sufficiently hard not to run. On the body a piece of impermeable adhesive plaster may be placed over the anointed spots, the patch of plaster being sufficiently large to overlap the ointment by half an inch. Another basis which he found of great use consists of a mixture of equal parts of almond oil and thick gum-water. This makes a creamy emulsion, which, when well rubbed into the skin, soon dries and leaves an almost invisible coating. A fifteen to twenty-per-cent solution of salicylic acid in this oil-gum is recommended in cases of chronic eczema and lupus, and a ten-per-cent solution of pyrogallie acid proved very efficacious in psoriasis. No protective dressing is necessary. He then notices Pick's gelatin and glycerin base, as modified by Unna and Beiersdorf, the only drawback of which is its deficient adhesiveness. This he has endeavored to remedy by the addition of gum. Collodion, especially flexile collodion, is another useful base, as is also compound tincture of benzoin. This being thin and limpid, penetrates well and adheres firmly. Lastly he recommends that tar should be applied as an ethereal and alcoholic tincture; if this be painted on the skin it quickly dries, leaving only a brown stain with very slight odor. The tar tincture thus forms a smooth, protective, and almost waterproof covering, which may also be made to serve as a vehicle for other drugs, as salicylic acid, zinc oxide, etc.

### The Removal of Superfluous Hairs by Electrolysis.

In this paper (*Birmingham Med. Review*) Mr. Gilbert Smith, after referring to the writings of Hardaway, White, and Piffard, proceeds to describe the apparatus needed, and the now well-known method of operating. Under a strong lens he finds that it is not difficult to introduce the needle directly into the follicle, but this is not absolutely necessary, as the requisite destruction occurs if the instru-

ment is in the immediate neighborhood. He recommends that not more than a dozen hairs should be removed at a sitting, owing to the papules and pustules which follow the operation, and says that minute scars are most apt to occur where it has been found necessary to introduce the needle into the same follicle a number of times, or where hairs situated close together are removed at one time; but even the most marked scars are scarcely noticeable after the first few weeks. He says that the operation is accompanied by pain which "is not unbearable," and that no return of hair has occurred in cases on which he has operated six months ago.

### A Case of Recovery from Malignant Pustule.

Dr. W. E. Buck relates the following case (*Brit. Med. Journ.*): A veterinary surgeon, aged 31, felt a stinging sensation at the back of the right wrist; a small bleb formed, which he scratched off, and there was some tenderness of the elbow and armpit. He had a slight rigor. Two days later he was seen by a physician, who found the temperature  $104^{\circ}$ , and prescribed aconite and sodium salicylate. The rigors were repeated, and a black eschar began to form, which on the following day was about the size of a sixpence; its base was red and surrounded by a ring of vesicles. "Pure carbolic acid" was now injected under the eschar by an ordinary hypodermic syringe. Unfortunately, only a small quantity could be introduced, as it oozed out in the withdrawal of the syringe, and with it a serous fluid. Some of this was dried on a cover-glass and, after staining with methyl-violet, showed the well-known bacilli of anthrax. Large and frequent doses of sodium hyposulphite were now prescribed, and a large quantity of meat ordered. (An exclusive meat diet?) Under this treatment he rapidly improved. Three days later the injection of carbolic acid was repeated, and, as the patient felt well, the hyposulphite was diminished. The eschar did not finally separate for nearly six weeks, and the ulcer then soon healed. The disease was contracted exactly twelve days before its first appearance, by the examination of an animal which had died of anthrax. In connection with this subject we may notice the communication of Mr. Arthur Barker to the Royal Medico-Chirurgical Society, on November 24th last, "On the Distribution of *Bacillus Anthracis* in the Human Skin in Malignant Pustule." The part examined was excised on the tenth day after its first appearance, and the patient made a rapid and complete recovery. The bacilli occurred chiefly in the most superficial parts of the derma. Enormous colonies were found spreading over the surface of the papillæ, causing vesiculation of the epidermis; while in the deeper parts of the cutis, and in the bodies of the papillæ, only a few could be discovered; none at all could be found in the blood-vessels. It therefore appeared that the disease remained essentially local for a considerable time. Mr. Davies Colley did not think it was local for more than a day or two, after which bacilli anthracis were to be found in the sputa, urine, sweat, and fæces. Notwithstanding this wide distribution, the patient might recover.

### The Leprosy Bacillus.

Dr. Lindsay Steven (*British Medical Journal*) has carefully examined a portion of affected skin excised during life, Gram's method being employed. Bacilli were present in enormous numbers, and were situated in rounded masses of granulation tissue, as well as in more diffuse infiltrations of round cells, but scarcely, if at all, in the more normal portions of the sections; none were met



with in the epidermis. The bacilli were contained within swollen lymphoid cells, and were also free, their general arrangement being often suggestive of their being contained within the lymphatic spaces. No bacilli were found in the blood-vessels. When examined by very high powers (1,600 diams.), they were seen to be fine rods, often sharply pointed at each extremity, and almost all of them contained small rounded spores, from three to five in number, giving a beaded appearance, and were certainly finer and smaller than tubercle bacilli.

### The Treatment of Lupus.

Dr. Payne, in his valuable "Report of the Department for Diseases of the Skin in St. Thomas' Hospital" (*St. Thomas' Hospital Reports*, Vol. XIV.) gives an account of several cases which were treated by a local application of perchloride of mercury, as advocated by Doutrelepon. The mode of application was at first to keep the surface covered with a watery solution of corrosive sublimate applied on lint, and covered with oil-silk or gutta-percha. This being difficult to apply to out-patients, a sublimate solution mixed with glycerin was tried, to be applied several times a day; but the most satisfactory plan was to apply collodion containing the remedy in solution. The effect is that: (1) Points of suppuration appear in the lupus tissue, or a moist excoriated surface is produced; (2) this heals, and the lupus in that part is wholly or partially cicatrized, so far as the remedy has acted. In superficial patches, complete destruction of the lupus tissues is effected; in thick masses, the destruction is only partial. The process is sometimes painful, and sometimes not. The strength of solution employed was in the first instance gr. ss. ad  $\frac{3}{4}$  i.; afterwards the strength was gradually increased up to gr. iv. ad  $\frac{3}{4}$  i. Dr. Payne notes that this method of treatment, however useful, is by no means better than removal of the diseased tissue by scraping, which he still believes to be by far the best treatment in the first instance.

### Cases of Syphilis Treated with the Tannate of Mercury.

Mr. Inglis Parsons (*Medical Times and Gazette*) gives an account of seventeen cases treated in the out-patient department in Guy's Hospital, the drug being given three times a day in pill an hour before meals, in doses of gr. iss. to gr. ij.; in one case gr. iiij. No opium or tonics were ever given with it, nor were they ever required. It seemed possible to give it for any length of time without disturbance of the general health. As, however, all the cases ceased to attend after about four or five weeks, a longer attendance being quite exceptional, this point requires further observation. The cases came under treatment in periods varying from one week to twelve months from the onset of the disease, and the symptoms disappeared in most cases in from two to five weeks; one case showed only "slight improvement" after three weeks. In four cases there was slight soreness of the gums, and in three cases the bowels were a little loose, but severe stomatitis or diarrhoea did not occur in any case, and the patients usually said they felt better for the medicine.

JOHN CAVAFY.

LONDON.

## Selections.

---

### ICHTHYOL AND RESORCIN.

WHATEVER Unna writes, it behooves us to read, even though we may not always fully agree with him; he certainly is a most suggestive writer. His last contribution under the above title is a study of the effects of these comparatively new drugs in dermatological practice, which is valuable to us as a guide in their use, the practical experience of an observant clinician being always valuable. The first portion of the article is a restatement of his views upon cornification ("Ueberhautung und Ueberhornung"), the action of ichthyol and resorcin being upon the same principle as that of pyrogallol, chrysarobin, etc., that is, they are reducing agents, drawing oxygen from the tissues. These agents act differently, according to the strength of the preparation, and as to whether they are used upon the sound skin, the denuded skin, or upon skin affected by parasites. The action of weak strengths shows itself in alteration of the corneous layer of the skin; it becomes thicker, denser, and more solid, and many rows of uncornified prickle cells are added to the normal corneous layer, which are probably made up for by new formation of the lowest prickle-cell layers. When the weak action is long continued, there results a division of the corneous layer into two parts, an upper, more or less dark, dead part, and a lower, light-colored part. Another effect of weak strengths of these agents is pustulation, on account of an abnormal closure of the mouths of the follicles by the hypertrophied corneous layer and consequent perifolliculitis.

If the action of the reducing agent goes deep, we have a permanent narrowing of the blood-vessels, and the skin becomes cooler, less swollen and painful, and paler.

All reducing agents discolor the corneous layer of the skin. Resorcin colors it dirty yellow when ointments are used, reddish-brown when in form of plasters. Ichthyol produces a yellowish-brown, like what is seen in sunburn. This discoloration is always more marked in the presence of an alkali. By long-continued use of the agent, the tendency to discoloration is lessened.

The action of high strengths of these agents is the same as that of low strengths, as far as the corneous layer is concerned, only more rapid. But new effects are produced elsewhere. The prickle-cell layer decays and softens, and bullæ appear; the walls of the papillary blood-vessels are damaged; exudation and, finally, emigration of pus-corpuscles takes place; the corneous layer is more and more deeply undermined, and at last thrown off as a continuous membrane. With resorcin and ichthyol, this process requires days or weeks. The subsequent cornification takes place more rapidly and strongly than under any other class of agents, and the cicatrix is therefore smoother and more even. If pustules are present, their covers are thrown off, and not reformed; hence, in acne, furuncles, etc., high strengths should always be used. Upon cicatrices of small-pox and acne, and upon the indurated skin of eczema, scleroderma, and elephantiasis, high strengths exert a softening influence. The first effect of these high strengths is to cause slight pain, which later may become quite severe, especially when pustulation or degeneration of tissues takes place.

Pure ichthyol, or strong applications of resorcin, used upon a simple lesion of continuity, such as an incised wound, will cause an instantaneous shrinkage, and a healing without scar. They have a good effect upon burns, so long as the bullæ are small and intact. Applied to raw surfaces they produce a high grade of catarrhal inflammation, œdema, and pain. On the other hand, when injected into the subcutaneous tissues, into suppurating glands, fistulæ, and the like, they produce a primary rapid union without inflammation. It may be given as a general rule, that the poorer a tissue is in blood-vessels and nerves, and the drier it is, the better will it bear strong doses of these agents. Applied to lesions of the skin in proper dosage, there follows a reduction of the productive elements of the skin and a preponderance of the supporting elements, and hence a tendency to cornification and healing. *Ichthyol*, of which Unna always uses the ammoniasulphate (sulfoichthyolsaure ammonium), is of great use in *Rosacea*, of which disease he recognizes two forms, one approaching to a usual erythema and eczema, with bright-red color, smooth or easily scaly skin, without comedones or acne; the other consisting of a papular acne upon bluish-red, swollen base. In the first form a low strength of ichthyol is to be used, in the form of ointment or paste; or washing with ichthyol soap and hot water, and the internal administration of the drug. In the second form the drug is to be used liberally, both internally and externally. Under its use in either form a rapid paling of the surface takes place, a thinning of the epidermis and disappearance of lesions.

It is useful in *acne*, whether pustular, papular, or indurated, employed both inwardly and outwardly, and in full doses.

The author recognizes two chief groups of *eczema* in which ichthyol does good one depending upon nerve action, and the other upon parasites. "Nervous eczema" affects chiefly adults, appears in a multiple manner, with an inclination to symmetry. Its lesion is a vesicle, which is full and does not break down so readily as in other forms. These vesicles come out in groups like zoster, and are to be differentiated from it by want of inflammatory areola and pain, and by their slower course and intense itching. The groups follow nerve courses, and tend specially to affect the extremities. This form is prone to relapse, and is brilliantly amenable to ichthyol administered internally and externally. At first it may be painted on in almost full strength on the extremities; in ten-per-cent watery solution on the face. As soon as the skin becomes dry under its use, it is to be stopped and not used again until a fresh eruption appears. The internal use is to be continued. To this same form of eczema belong those cases occurring with periodic attacks of asthma. Here ichthyol given by the mouth acts favorably upon both the asthma and the eczema. Children can take five to ten drops daily, in wine or beer, and if a relapse takes place the dose is to be increased four or five times for a few days.

The chief parasitic form of eczema is that occurring in strumous children, affecting the openings of the body (nose, mouth, etc.), and complicated with other signs of scrofula. It is not very itchy, but is erythematous, moist, tends to crust, and causes a great deal of œdema. Here ichthyol is a reliable drug, given by the mouth, in daily doses of five drops, and used externally in say five-per-cent strength, according to the condition of the skin. Another form of parasitic eczema is that which attacks opposed surfaces—the intertrigo form. Here ichthyol is to be applied in ten-per-cent ointment, and one rubbing will often cure a fresh case.

Upon other parasitic troubles, as Unna regards them—*pityriasis capitis*, *sebor-*

*rhœa sicca capitis, eczema seborrhœicum, furunculosis, erysipelas, and erysipeloid*—the drug exerts a no less wonderful influence, when used in ten to fifty per cent ointment. In the treatment of *psoriasis, sycosis, and lupus*, ichthyol is but an adjuvant, though a useful one. It is useful after the treatment of *lupus* to bleach the skin and smoothe the scar.

*Lichen urticatus* is very promptly cured by the internal use of ichthyol. *Urticaria, erythema multiforme et nodosum, herpes progenitalis et labialis, zoster, and dermatitis herpetiformis* are all favorably influenced by ichthyol in high percentage externally, while the chronic cases get well rapidly under internal administration of the drug.

Applied in full strength to flat *condylomata*, ichthyol removes them without a scar; but its use must be continued for some little time after their disappearance to insure against a return. *Keloid*, especially of the cicatricial kind, occurring on the face, can be removed by repeated applications of a strong ointment or colloidion solution.

Ichthyol, then, is a very useful drug in conditions in which we have an abnormally soft thin cuticle, as in subcutaneous swelling and inflammations with sound surface (furuncles), in œdemas, angiectases, inflammations and new formations of the skin without implication of the cutis (urticaria, rosacea, etc.), in inflammatory processes of the skin with hyperkeratosis (acne), or at least without loss of resistance of the cuticle (herpes, etc.), and in parakeratoses (psoriasis, pityriasis, etc.). In all these the drug can be used in full strength. The amount of the drug to be given by the mouth is regulated more by the individual than by the dermatosis. The minimal dose is, for children; about two drops; for larger children and adults, five drops a day. For most people the dose can be raised to five or ten drops of the ammoniac-sulphate three times a day. When the full dose is reached, it should be continued for some time.

The internal administration is of special use in chronic, obstinate, relapsing skin diseases.

*Resorcin* has not so wide a field as ichthyol. It is useful in *pityriasis capitis, alopecia pityrodes, squamous eczema* of the head, and seborrhœal eczema, in the form of a 5 to 10% ointment, according to the amount of inflammation present. Sometimes it is necessary to use a 20 to 30% ointment to overcome a stubborn remainder from the disease. In *psoriasis* it acts well in 10 to 20% ointment. It is useful in several forms of parasitic (?) *eczema*, as where it occurs in the form of dry itchy patches upon the face, or in the form of small, round, sharply circumscribed, scaly patches resembling pityriasis versicolor, or in the form which occurs about the openings of the body; also in a form which resembles psoriasis, differing from it only in that the fine scales lie centrally on the papule, leaving its red border free; the scales never reach the magnitude nor attain the silvery look of those of psoriasis; the papules often have a depression in the centre, and are very itchy; it is further distributed over the body and does not specially affect the elbows and knees. Also in the form of *eczema flavum, lichen circumscriptus, or eczema acnéique*. In all these resorcin renders good service, especially if they are located on the face. It is well to begin with a 2% ointment or paste and gradually increase its strength with the progressive healing.

It is of great service in *ichthyosis, in trichophytosis barbae, and in cicatricial keloid*. Further good results are had from it in *erysipelas and epithelioma*.—*Monatschrift. f. prakt. Dermatol.*, May, 1886.



### THE MICROBE OF SYPHILIS.

THE following account of some of the most recent investigations in this subject is abstracted from the *Wiener Medizinische Wochenschrift*, No. 14, 1886. At a recent meeting of the Berlin Society for Internal Medicine, Klemperer reported that he had treated preputial smegma, taken from nine healthy individuals, according to Lustgarten's method. He found in every specimen the smegma-bacilli described by Alvarez and Favel. These, like the syphilis bacilli, differ so greatly in length, thickness, and form that there is some doubt whether they belong to the same species. They resembled the syphilitic bacilli in appearance and in reactions, but were more readily decolorized by acids and alcohol than were the latter. The speaker had found Lustgarten's bacilli in the secretion of broad condylomata, but had never found them in sections of condylomata, indurated patches, or gummy tumors. Köbner said he had found the presence of the bacilli in the secretions, and especially in sections, of syphilitic lesions to be very inconstant. He doubted the identity of Lustgarten's bacilli with the syphilitic virus. Finger had shown that the micro-organisms were present in the secretions in all three stages of syphilis. Were, then, these bacilli the bearers of the specific virus, he did not understand why the disease could be transmitted by the secretions in the first and second stage, but never by those of the third.

In an article on the "Contagium of Syphilis," in the *Deutsche Medicinische Wochenschrift*, Disse and Faguchi state that they have found spores in the blood and short bacilli in the indurated patches and papules of syphilitic patients. They also obtained from the blood of syphilitics pure cultures in gelatin and meat-broth of a bacillus, which caused syphilis in dogs, sheep, rabbits, and white mice when inoculated. An induration occurred at the point of inoculation, and was followed some months later by gummy tumors in the internal organs. From the blood of these animals could be cultivated the same bacillus as from the blood of syphilitics.

Matterstock has recounted in a pamphlet the results of his studies in the clinic of the University of Würzburg. He found the bacilli corresponding to Lustgarten's description, in sections made from sclerosed patches, papules, broad condylomata of the genitals and anus, and gummy tumors of the skin. These lay, from one to four together, in cells two or three times the size of white blood-corpuscles; and in rare instances a few solitary rods were found lying free between two cells. The bacilli were found in great numbers in the secretion of papules, which, from their protected situation, covered with long-standing secretion, and kept at a constant temperature, resembled miniature culture-ovens. Experiments upon the smegma-bacilli had led to the same results as those obtained by Alvarez and Favel. He had found no reliable means of distinguishing between these and Lustgarten's bacilli by staining methods. His conclusions were that not only was the etiological significance of Lustgarten's bacilli not demonstrated, but even their diagnostic value was nil, since they could not be distinguished by their reaction to coloring agents from other bacilli.

### POLYMORPHOUS ERYTHEMA: ITS NATURE AND ITS SPECIFIC TREATMENT.

M. VILLEMEN, in a communication to the Académie de Médecine upon "Polymorphous Erythema; its Nature and its Specific Treatment," discusses the question whether this affection is allied to rheumatism or is assimilated in its general

characters to the infectious diseases. He says: If therapeutic specificity implies etiological specificity, if the same remedial agent causes the various eruptions comprised under the term polymorphous erythema to promptly disappear, and the same time dissipates the other general symptoms, such as fever, rheumatism, pain, and other disorders of the nervous system, we shall have the right, it seems to me, to consider these moot points as to its nature settled, and to affirm that:

1. The erythemas to which dermatologists have given the names of nodose, papular, circinate, vesicular, etc., and which are embraced under the common name of polymorphous erythema, are only varieties of the same morbid type.

In the evening your patient may have a high temperature, a bright-red, indurated, painful erythema, a distressing lumbago, severe pains in the limbs and in the joints, prostration, insomnia, etc. The next morning all is changed; the temperature is normal, the erythema has paled, lost its induration, and is disappearing; the pains have vanished, the articular swellings are dissipated, and in three or four days not the slightest trace of the disease remains.

The higher the fever the more marked its fall. In twelve hours we sometimes see the temperature diminish three degrees. The pains are allayed almost as promptly as the fever, but when swellings and œdemas are present, time is, of course, necessary for the absorption of the extravasated fluids.

In addition, the use of the iodide of potassium has always sufficed to abort the tendency to relapses which are so frequent in this affection.

Auto-inoculation of the contents of the vesicle has been tried, but thus far with negative results. Villemin's conclusions are based upon his observations in twelve cases treated by him.

2. That polymorphous erythema is a general disease of a specific nature, of which the cutaneous eruption is only a syndrome.

3. That the pains in the fibrous tissues and the articular swellings are not related to rheumatism, but are manifestations of the disease and are produced as the cutaneous eruption itself is, by a unique morbid cause. The remedial agent to which allusion has been made is the iodide of potassium. The *materia medica* possesses no other agent so marvellously specific as is this salt in polymorphous erythema.

In from twenty-four to forty-eight hours, and with an average dose of thirty grains per day, all symptoms of the affections are simultaneously modified in the most surprising manner. Quinine has certainly not in intermittent fever such rapidity and such certainty of action.—*Bulletin de l'Académie de Médecine*, No. 20, 1886.

## CONTRIBUTION TO THE STUDY OF SYPHILIS OF THE INFERIOR MAXILLA.

THE inferior maxilla is not, as certain authorities have contended, secure from the attacks of syphilis. Specific disease of the inferior maxilla may present itself under diverse forms, giving rise to difficulties of diagnosis and to therapeutic indications which vary in different cases.

Specific lesions of the inferior maxilla may result from either hereditary or acquired syphilis, and present themselves under three different forms, 1st, under the form of periostitis or gummous osteo-periostitis; 2d, under the form of exostoses or hyperostoses; 3d and finally, under the form of progressive rarefactions and disappearance of the dental alveolar arches.

Gummous periostitis may be accompanied with ulcerations of the same nature, either of the skin or mucous membranes; it may be partial or diffuse; it may develop at a relatively early period of syphilis; its terminations are variable, depending upon whether the patient receives specific treatment or not. Where specific treatment is instituted in time, complete resolution may take place without leaving a trace, or there may remain exostoses or hyperostoses, resulting in a more or less marked deformity of the maxilla. If the affection is abandoned to itself, the most frequent termination is necrosis, more or less extensive, of the inferior maxilla, and, in this latter case, may require a surgical operation involving a partial or total resection of the lower jaw. Sometimes there result spontaneous fractures of the maxilla.

The diagnosis of gummous periostitis of the maxilla, especially if accompanied with ulceration, may be extremely difficult; it should be differentiated from simple alveolo-dental periostitis, from phosphorus necrosis, from osteo-sarcoma, and also from tuberculosis when the ulceration occurs on the mucous surfaces.

Exostoses and hyperostoses of the inferior maxilla may occur as a result of gummous periostitis (Otto Weber). They occasion no inconvenience aside from their presence and the deformity of the bone upon which they are situated. They may compress the inferior dental nerve. Antisyphilitic treatment dissipates them in a certain proportion of cases.

The progressive resorption of the alveolo-dental arches is characterized by the loss of the teeth, and the total disappearance of the dental arches. This spontaneous loss of non-carious teeth is sometimes accompanied by severe hemorrhage. The duration of the affection is quite protracted.

The treatment of syphilis of the inferior maxilla does not differ from that usually employed in osseous syphilis in general.—DR. F. CHABAUD, *Thèse de Paris*.

### SYMMETRICAL GANGRENE AND LOCAL ASPHYXIA.

DR. O. KOERNER, of Frankfort, reviews, in the *Centralblatt für klinische Medizin* of May 29, an article by Dr. Hochenegg which appeared in Heft 4 of the *Med. Jahrbücher* for 1885, on symmetrical gangrene and local asphyxia. Symmetrical gangrene is a form of spontaneous gangrene, caused by nervous disturbances of a trophic or vaso-motor nature, or by an unknown vicious blood mixture. It is not an independent disease, but a symptom that may represent the most different maladies. Only a small proportion of the cases are followed by simple gangrene, the majority being found in combination with the symptoms of another fundamental disease which stands in etiological relation to it. Such diseases are disturbances of nutrition, as those which appear after severe physical exertion, especially if continued during a number of days without stopping. Further, those cases that appear in chlorotic and chronically anæmic individuals, and especially with children. Also the sequelæ of acute infectious diseases belong to this category.

Hysteria is given as an example, the symptoms of which symmetrical gangrene may accompany, and it is further maintained that symmetrical gangrene and local asphyxia may constitute a symptom of neuritis. Dejerine and Leloir, Monnstein, Pitres, and Vaillard are quoted as authorities for this. It seldom occurs with acute, but most frequently with chronic, very slowly progressing neuritis. It is often limited to peripheral localities, for instance, the extremities, the main trunk of the nerve remaining intact. It may also be derived from brain

disorders or diseases of the spinal cord without the appearance of peripheral neuritis. Syringomyelia is given as an instance among others of this nature. When accompanying diseases of the central nervous system, Hochenegg regards symmetrical gangrene as analogous to Charcot's acute decubitus, but does not view it as being of so ominous a nature.

Aside from the treatment of the causal disease, the application of dry heat, in the form of dressing with cotton, and extending considerably beyond the diseased parts, is recommended as the best method. The changing of the bandages must take place in a warm room. Electricity and irritating salves are dangerous in the extreme. If acute gangrene in symmetrical form sets in, it is to be treated surgically, the same as ordinary gangrene. Hochenegg observed five cases among seven thousand hospital patients.

## Books and Pamphlets Received.

La Syphilis Héréditaire Tardive; Leçons Professées par ALFRED FOURNIER. Avec 31 figures par Alfred Fergeron. Paris: G. Masson, Editeur, 1886. Will be noticed in subsequent number.

Apuntes para el Estudio de los Queratomas, por los Doctores D. ALFREDO R. VIFORCOS and D. LEOPOLDO LOPEZ GARCIA. Con once Grabados Intercalados en el Texto. Madrid, 1886.

Zur Topographie der Bacillen in der Lepra-haut, von DR. K. TOUTON, in Wiesbaden. Reprint.

De la Methode à suivre dans le Traitement du Lupus Erythémateux et de certaines autres Dermatoses, par le DR. BROCC, Médecin des Hôpitaux. Reprint *Journal de Méd. de Paris*, June, 1882.

De la Destruction des Poils par l'Ectrolyse, par le DOCTEUR BROCC. Extrait des Bull. et Mem. de la Société Médicale des Hôpitaux de Paris.

On the Affections of the Skin Induced by Temperature Variations in Cold Weather, etc., by JAMES NEVINS HYDE, M.D., Chicago, 1886.

Hydroa, by H. RADCLIFFE CROCKER, M.D., M.R.C.P. Reprint from *British Medical Journal*.

On the Limitation of the Contagious Stage of Syphilis, especially in its Relations to Marriage, by PROF. F. N. OTIS, M.D. Reprint from the C. AND V. JOURNAL.

Il Ferrato di Mercurio—Nuova Medicamento per la Cura della Sifilide, pel PROF. CAV. PIETRO GAMBERINI.

Casuistisches zum Lichen Ruber Planus der Haut und Schleimhaut, von DR. K. TOUTON, in Wiesbaden. Reprint *Berliner Klin. Wochenschr.*, 1886.

Hard Chancre of the Eyelids and Conjunctiva, by DAVID DEBECK, M.D., Assistant to Chair of Ophthalmology, Medical College of Ohio. 1886.

Bericht über die Verhandlungen der Deutschen Gesellschaft für Chirurgie, XV. Kongress. Reprint from *Centralblatt für Chirurgie*, No. 24, 1886.

Bericht über die Verhandlungen des V. Kongresses für Innere Medicin. Reprint from *Centralblatt für Klin. Medicin*, No. 25, 1886.



JOURNAL  
OF  
CUTANEOUS AND VENEREAL DISEASES.

---

---

VOL. IV.

OCTOBER, 1886.

No. 10.

---

---

**Original Communications.**

---

TROPHONEUROSIS OF THE SKIN CAUSED BY INJURY TO THE  
MEDIAN NERVE.<sup>1</sup>

BY

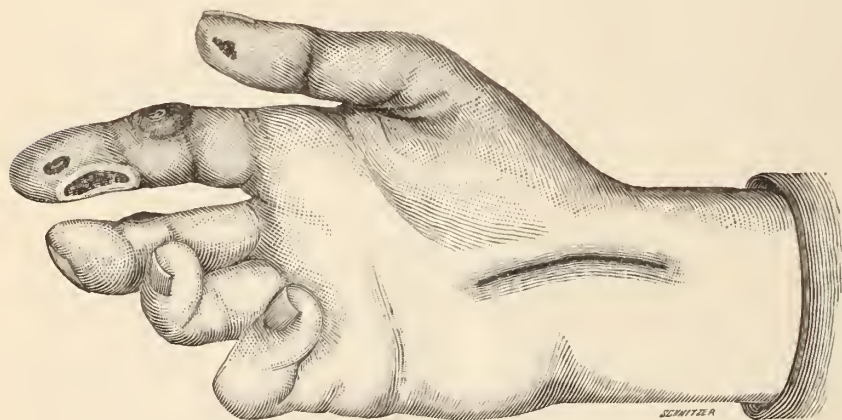
G. H. TILDEN, M.D.

**E.** F., 55 years of age, a carpenter by trade, was wounded in the wrist by a circular saw on November 10, that is, exactly four months before coming under observation. The linear cicatrix resulting from this wound is about two and one-quarter inches in length, and its direction parallel to the long axis of the arm. It is situated on the flexor surface of the right wrist at about the middle line, and being slightly curved, its convexity is directed toward the ball of the thumb. The wound was sewed up immediately after the accident, and union took place in about ten days, at the end of which time the stitches were removed. Three or four days after the infliction of the injury, the patient began to be conscious of a loss of tactile sense and feeling of numbness in the last two phalanges of the fore and middle fingers, which disturbance of sensation has continued and steadily increased in severity ever since. There was also evident, at first, a similar feeling of numbness in the thumb, but to a less degree, which has been gradually diminishing, and is now no longer experienced.

About three weeks after the accident, there appeared for the first time a bulla, situated upon the terminal phalanx of the index finger, and since then similar lesions have developed from time to time upon the last two

<sup>1</sup> Read at the 10th annual meeting of the American Dermatological Association.

phalanges of the fore and middle fingers. These bullæ are about the size of a pea, their epidermal covering is tense, and they are filled with a clear serous fluid. They make their appearance every two or three weeks, are unaccompanied by any subjective sensation, being rapidly developed generally during the night, and do not increase in size after having once been formed. The region of the skin upon which they are situated is reddened to a slight degree before they make their appearance. Removal of their epidermal covering discloses a superficial excoriation which heals in a week or ten days. When several of these lesions have been developed successively in the same spot, there is finally produced a condition of thickening and accumulation of epidermis, a true tylosis, such as is shown on this side of the forefinger in the portrait, and it has been the custom of the patient to pare down these accumulations of epidermis with a razor. About two weeks before I first saw him, the largest



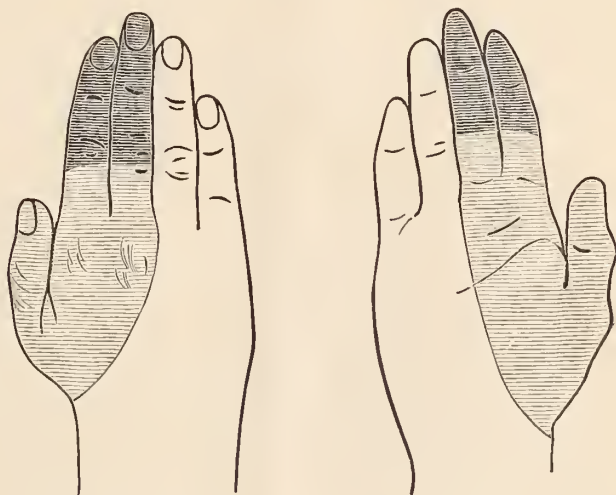
bullæ which had yet appeared was developed, giving rise to the ulcer situated on the inner side of the tip of the forefinger.

The skin in general over the last two phalanges of the affected fingers, more particularly on their dorsal surfaces, is tense, of a white color and glossy texture, while these fingers upon palpation offer a sense of solidity, of greater resistance, and less elasticity of tissue than is furnished by the other fingers. The growth of the nails is unaffected. The region of the cicatrix in the wrist is somewhat sensitive to pressure, and there is entire loss of sensation in the last two phalanges of the fore and middle fingers. Dr. W. N. Bullard kindly examined the patient for me with reference to a more exact determination of the condition of the hand as regards loss of sensation, motive power, and reaction to electric stimulus.

In the portion of the hand designated by light shading there was partial anæsthesia, the patient being able to distinguish between the point

and head of a pin. In the last two phalanges of the fore and middle fingers, the region indicated by dark shading, there was total anæsthesia and analgesia, inability to make distinction between two points and one, and absence of the temperature sense. Tested by the dynamometer, the right hand was capable of exerting but one-half the force of the left. The reaction of all the muscles in the anæsthetic region was diminished to the faradic current, while the galvanic current excited the so-called degeneration reaction in the first and second interossei muscles.

Six weeks' treatment, in the shape of the application of the faradic current to the hand and forearm, caused decided improvement in all the symptoms, both subjective and objective. The power of motion and muscular force increased, the sensation of numbness in the fingers became



much less marked, while the tenderness upon pressure over the cicatrix in the wrist disappeared entirely. But one bulla was developed during the time of treatment, and the ulcer on the forefinger nearly healed.

The patient then gave up treatment and resumed work, using his right hand to manipulate a hammer. No particular change in the improved condition of the hand was noticed until the end of about three weeks, when quite suddenly all the subjective symptoms reappeared, the fingers became stiff and their power diminished, the feeling of numbness in them returned, while the sensitiveness to pressure upon the cicatrix in the wrist became again manifest. I saw him at this time, and a freshly formed bulla had developed upon the back of the second phalanx of the middle finger. The ulcer which had formerly existed on the inner side of the forefinger was transformed into a crater-like callus, the

thickened epidermis being arranged in concentric rings around the centre, which presented a small blood crust covering an excoriation. The whole skin of the end of the forefingers was extremely thickened and indurated, doubtless on account of the friction caused by the use of the hammer, these changes in the epidermis being apparently much greater than could have been occasioned by the same amount of friction applied to normally innervated skin. The hand was in fully as useless a condition as when he was first seen, all that had been gained by treatment having been lost.

It was proposed to the patient that an incision be made in the region of the cicatrix, with the intention of finding out the exact condition of things, and if possible to remedy them. This was the last time I saw him, although he promised to return after having made up his mind as to the operation.

The evidence that there are nerves which control in some way the nutrition, the growth and repair of tissue, is a matter of inductive reasoning rather than of anatomical demonstration. Whether these nerves exist as individual and special nerve fibres, or whether the motor and sensory nerves are the ones by which the nutrition of tissues is governed, is unknown. The latter seems to me to be the more rational view, namely, that the so-called trophic influence is transmitted from the nerve centres and ganglia to the tissues by the motor and sensory nerve fibres, and that interference with the conducting power of these nerves, by disease or injury affecting them at some part of their course, as well as disease of the ganglion and central nervous system, may disturb, not only motor power and sensation, but also the nutrition of tissues. That it always does so is by no means the case, but why trophic changes should take place in one instance and not in another is not clear.

Leaving out of consideration instances of trophic changes in the skin due to disease of the nervous system, the most notable examples of which are furnished by zoster, perforating ulcer of the foot, some forms of leprosy, and so-called symmetrical gangrene, cases of similar changes in the skin caused by injury to the nerves are not uncommon, a number of instances being given by Mitchell and by Leloir.

Such changes are more apt to follow partial injury to a nerve than complete section thereof, and there very commonly exists in these cases a condition of chronic irritation of the injured nerve fibres, occasioned by pressure, constriction, or inflammatory processes. A noteworthy example of this is furnished in a case reported by Paget, in which the median nerve was compressed by a large callus, resulting from fracture of the lower end of the radius. "The thumb and first and second fingers ulcerated; and the ulcers resisted all treatment until the wrist was kept bent in such a way as to relieve the nerve from pressure. The ulcers re-



turned whenever the hand was allowed to resume its former position."

The changes in the skin commonly seen in these cases are the condition of so-called glossy skin and vesicular and bullous eruptions, followed by superficial ulcerations, which, as a rule, readily heal. Tyloitic changes may occur as in the present instance. The treatment in these cases consists in the application of electricity to the injured nerve, and of blisters over the seat of injury. A last resource is to cut down upon the affected nerve, and endeavor to relieve by surgical means any constriction of or pressure upon the nerve which may be found to exist. If no such condition of things can be detected, resection of a portion of the nerve might be advisable, since complete section of a nerve is not likely to be followed by spontaneous trophic changes, and since, according to Leloir, it has been found by Brown-Séquard and Verneuil that resection of portion of the affected nerve is sometimes followed by the arrest of trophic changes.

---

#### NOTES ON DRUGS.<sup>1</sup>

BY

HENRY G. PIFFARD, M.D.

**U**NGT. *Hydrargyri Ammoniaci*.—Until within about three years, the white precipitate ointment has been with me a favorite application in moist eczema, and during a period of about eighteen years I can recall but two or three accidents with it. Since then, however, that is, during the last three years, its use has so frequently been followed by symptoms of irritation that I had well-nigh abandoned it. A comparison of the officinal preparation now furnished, with that formerly in use, explains, I think, the observed differences in their effects. The present ointment is made with pure lard, while formerly it was made with lard and wax. The pure lard tends to promote the absorption of the mercurial, and thus explains, I think, its irritating effects. The present ointment is too soft, and mechanically is not as good as the older preparation. For some months I have been using an ointment made with *ceratum cetacei* instead of the officinal preparation, with satisfactory results.

*Acidum Sulphurosum*.—The present officinal preparation is only about half the strength of that prepared according to the late pharmacopœia. Squibb, however, retains the latter preparation, and care should be exercised in prescribing, lest one preparation should be inadvertently substituted for the other.

<sup>1</sup> Read at meeting of American Dermatological Association, Aug. 26, 1886.

*Traumaticin*.—Under this name, several manufacturing firms offer a ten-per-cent solution of gutta-serena in chloroform, equivalent to the *Liq. Gutta-serena* of the pharmacopœia. The preparation is clear and closely resembles collodion in appearance. Beside its usual employment as a vehicle for ehrysarobin, I have found it useful in the application of sulphur, bismuth, white precipitate, oxide of zinc, and other substances. The addition of a slight quantity of earmine renders the mixtures less noticeable when applied to the skin. Squibb's *liq. gutta-serena*, however, is dark in color, and, from an æsthetic standpoint, is not a desirable preparation.

*Lanolin*, or oil from wool, comes to us from abroad in the form of a soft, foul-smelling ointment. In this country it is protected by letters-patent No. 271,192. In the specifications, this new product is claimed to be a "perfectly white, neutral, colorless ointment," which description certainly does not apply to the article as supplied for sale.

The chief claims made in behalf of lanolin are, that it is more readily absorbed than any other fat, and that it promotes the absorption of medicinal substances combined with it. Since in the majority of cases we do not wish absorption, but surface action only, this property is a detriment, and lanolin is to be condemned as a general basis for ointments. An exception to this may be a combination of lanolin and tar, which, in suitable cases, appears to work better than the official tar ointment.

*Ichthyol* appears to me to closely resemble the old *oleum sulphuratum* or balsam of sulphur, and would doubtless obtain a recognized place in therapeutics, were it not that it has been, in this country at least, brought prominently forward as a general cure-all for cutaneous diseases, and advertised as such in the public journals, theatre programmes, railway stations, etc. This places it in the same rank as Cuticura and similar proprietary compounds, and removes it from the armamentarium of the scientific physician.

### A STUDY OF SIMPLE PAPILLOMATA.

1. SIMPLE papillomata or papillary hypertrophies may develop upon the external surface as the result of prolonged irritations.

2. They have as seats of predilection the backs of the hands, the fingers, especially in the neighborhood of the articulations.

3. These papillary hypertrophies possess in themselves no gravity, but they occasion from their localization and continual increase pain and difficulty of movement.

4. The patient may be compelled to suspend his occupation; therapeutic intervention is therefore indispensable. The only rational treatment is destruction of the papillomata, which may be effected by the curette or by cauterization.

—DR. EDWARD NATIN, *Th. de Paris*.

SCARLATINA AND SCARLATINIFORM ERUPTIONS FOLLOWING  
INJURIES AND OPERATIONS.<sup>1</sup>

BY

I. E. ATKINSON, M.D.,

Professor of Materia Medica and Therapeutics, and Clinical Medicine and Clinical Professor of  
Dermatology in the University of Maryland.

**A**LTHOUGH reports of scarlatina and scarlatinoid eruptions following injuries and surgical operations were to be found in medical literature, general attention was more especially attracted to them by Sir James Paget in 1864 in a clinical lecture. In his "Clinical Lectures and Essays" (1875) he devotes a chapter to the subject. He says: "There is something in the consequences of surgical operations which makes the patients peculiarly susceptible to the influence of the scarlet fever poison." In France, Trélat<sup>2</sup> was the first to accept the views of Paget concerning the nature of these rashes, though they had already been observed by Civiale, Germain Sée, Tremblay, and others. Rashes more or less resembling scarlatina were reported by Jonathan Hutchinson, Hilton, Bryant, Lea, Moore, and others, and in St. George's Hospital Reports for 1879 is a notable article by Stirling, in which the subject is considered. Scarlatinoid rashes in surgical cases had generally been considered to be of septicæmic origin. In Guy's Hospital Reports for 1879 appeared two papers supporting the proposition that an especial liability to scarlatina is shown by those who have recently sustained injuries or undergone surgical operations. The first of these, "A Contribution to the Etiology in Scarlatina in Surgical Cases," by W. E. Paley, was communicated by Goodhart with observations. It was based upon records of Evelina Hospital for Sick Children, and contained the reports of twenty-five cases. Of these patients, nineteen were shown to have been exposed to scarlatina, and of the remaining six, all save one had possible sources of infection. Goodhart, however, was careful not to assert that all such red rashes should be attributed to scarlatina. The scarlatinous nature of the cases reported in the paper will be everywhere admitted. The second paper was by House, and is based upon four cases of surgical scarlatina, occurring epidemically in Guy's Hospital. The epidemic ceased upon the establishment of isolation, and its scarlatinal nature cannot be doubted. While this author does not venture to affirm that there is *not* "such a thing as a rose rash in a typical case of septicæmia," he

<sup>1</sup> Read before the American Dermatological Association at Greenwich, August 26, 1886.

<sup>2</sup> *Le Progrès Médical*, Sept. 14, 1878.

believes "that the more these cases are studied, especially when the disease occurs in groups of cases and in patients that have been dressed antiseptically, the deeper will become the conviction that they have little in common with true septicæmia, and that they all originate in the first place in a true scarlatinal infection." Riedinger,<sup>1</sup> who reported ten cases of scarlatina after wounds and operations, reached his diagnosis from symptoms, and was only in one case able to trace a contagious influence. He also concluded that there exists in wounded persons a predisposition to scarlatina. At the International Medical Congress of 1881, in London, Mr. Howard Marsh and Riedinger re-affirmed this opinion, and, in the succeeding discussion, Holmes and Goodhart coincided with their views; the former, however, declared that many cases of "surgical scarlet fever" are due really to pyæmia and other causes.<sup>2</sup> It appears, therefore, that most recent writers decidedly incline to the opinion that these eruptions are generally dependent upon true scarlatina. When any tendency toward epidemic prevalence is shown, every one will agree with such conclusions—as much cannot be said of these rashes when occurring in isolated cases. Broadly speaking, all debilitating causes predispose those influenced by them to attacks of infectious disease. Is this more especially true of scarlatina?<sup>3</sup> A glance at Paley and Goodhart's figures is instructive. Of twenty-five cases observed, scarlatina attacked seventeen after operation; seven of them were without any wound whatever, and one had an old sinus only. Many of the cases of other writers had no external wound whatever. Unfortunately, reporters most rarely note whether their patients had ever previously had scarlatina. Most children, when first exposed to the contagion of this disease, become infected; is it remarkable that they are unable to withstand it when it attacks them weakened by injury or surgical operation? Trent, indeed, reasoning from imperfectly considered and insufficient data, has concluded that scarlatina is less apt to attack surgical cases than others.<sup>4</sup>

But, apart from epidemic influences, it is probable that scarlatiniform eruptions in the wounded may justly, in a large proportion of cases, occur quite independently of scarlatina. Rashes of septicæmic origin are well known to occur. Various fugitive eruptions often develop under nervous irritation of indifferent origin, as when they proceed from certain topical influences, or from various ingesta, whether as food or medicines, or, finally, from strong emotional disturbance. Urticaria and erythema not rarely follow surgical operations. Spencer Wells has seen a rash like that of scarlatina cover a woman's body in less than a quarter of an hour

<sup>1</sup> *Centralbl. f. Chirurg.*, No. 9, vii., 1880, 134.

<sup>2</sup> See *Transactions*, vol. iv., p. 177.

<sup>3</sup> Paley's figures show a like predisposition to measles under similar conditions.

<sup>4</sup> *Centralbl. f. Chirurg.*, No. 18, vii., 1880, 291.



after the application of perchloride of iron to a cauliform excrescence of the uterus. One patient always developed urticaria upon the introduction of the speculum.<sup>1</sup> Such idiosyncrasies are not uncommon.

The rashes of septicæmia are, it is true, usually urticarial in character, but often enough are erythematous, when they appear as large plaques, mingled or not with urticarial wheals, scattered irregularly over the body and of uncertain duration. It must be admitted that true scarlatiniform septicæmic rashes are not common.<sup>2</sup> But there seems to be excellent evidence that they do occur. How, otherwise than upon a theory of sepsis, using the term in a broad sense, are we to account for cases such as the following: Konetschke<sup>3</sup> treated a boy nine years old for compound fracture of both bones of the leg. The wound was dressed antiseptically as far as practicable. Two days after the injury (Aug. 14), the temperature was 40° C. (104° F.), and there appeared over the whole surface an exquisite scarlatina eruption, which was intensely red on the next day, and showed numerous miliary vesicles. This lasted six days and was followed by lamellar desquamation. Again on Aug. 26 the temperature rose (39.5° C.), and the scarlatiniform rash again appeared, lasting, however, only two days. Decided scaling again followed. Elevated temperature was again noted on Sep. 3d (39.2° C.), and a very characteristic rash again developed, lasted four days, and again desquamation followed. There was at no time angina or swelling of the submaxillary glands. There was no scarlatina in the neighborhood, and no extension of the disease took place. Equally discordant with a theory of scarlatinal origin is the following case reported by Ffolliott: <sup>4</sup> A private soldier of the garrison of Ali Musjid was burnt in an explosion of gunpowder on the face and arms and on the left hip and internal surface of the thigh. On December 25, four days after the accident, he had considerable constitutional disturbance, and a bright scarlet eruption appeared upon the belly. By the next day his whole body was as red as a boiled lobster. The temperature, at first 101° F., fell as the eruption developed. This disappeared in four or five days and was followed by general desquamation. The disorder was regarded as scarlatina by several medical officers. But the man had been three years in India; there was no scarlatina in camp, and Mr. Ffolliott had not seen or heard of a case in twelve years' service in India. Moreover, scarlet fever is a

<sup>1</sup> Consult also Batut, Thèse de Paris, 1882, No. 349.

<sup>2</sup> It is remarkable that a scarlatiniform rash is apt to follow lithotomy. Thomas Smith saw it seven times in forty-three lithotomies. Maunde, Broadbent, Callender, and others have seen it. Curiously, the rash in these cases often begins around the wound.

<sup>3</sup> Wien. Med. Presse, 23, 1882, p. 1483.

<sup>4</sup> Brit. Med. Journal, i., 1879.

disease practically unknown in that country.<sup>1</sup> Attempts have been made to establish a differential diagnosis for this surgical rash. Cheadle,<sup>2</sup> for example, claimed that in "surgical erythema" (1) there is no swelling of the tonsils, no enlargement of the glands, though the fauces may be reddened; (2) the strawberry tongue is absent; (3) the rash is not often universal, but is confined to the body and parts covered with clothes, the face remaining uninvolved; the eruption rarely lasts twenty-four hours, and is never followed by desquamation. These points are of no value. George May, Jr.,<sup>3</sup> thought he could diagnosticate the non-scarlatinous surgical eruption by the absence of the boiled-lobster appearance of the skin and by the mild lingual and faucial symptoms. Subsequently, however, he candidly admitted that the case that had served as a text for the expression of this opinion turned out to be one of true scarlatina.

A final etiological factor in the production of scarlatiniform eruptions is the ingestion of various drugs. These eruptions have received from numerous writers passing reference in this connection, but by no means the attention to which they are entitled. Scarlatiniform rashes may be evoked by the ingestion of belladonna, copaiba, opium, and morphia, chloral, mercury, and other drugs, but, above all others, as bearing upon our present subject, of cinchona and its alkaloids. These preparations are those most frequently given to persons who have been injured or subjected to surgical operations, and, beyond question, eruptions induced by them are often attributed to other causes. The quinine eruptions are only beginning to receive due attention, and are much more common than is generally supposed. They usually show the features of urticaria or simple erythema, and are associated with an interesting series of general phenomena. Other eruptive forms are also observed, but the one that concerns us at present is the scarlatiniform rash. This is not especially uncommon, and doubtless many obscure cases of "idiopathic," and "septicæmic," and "surgical" scarlatiniform rash should be properly attributed to it. This rash has been described now by many writers, among whom may be mentioned Bussy,<sup>4</sup> Levassor,<sup>5</sup> and, more especially, Morrow.<sup>6</sup> It may exactly resemble scarlatina. Persons possessing the idiosyncrasy often develop it after even the smallest doses of the drug. At the onset it often cannot be distinguished from scarlatina. Beginning with high fever, and often with sore throat, the eruption appears upon the chest, face, and neck, and within twenty-four hours the entire sur-

<sup>1</sup> Hirsch, "Historisch-Geographische Pathol."

<sup>2</sup> Brit. Med. Journal, ii., 1879, p. 75.

<sup>3</sup> Brit. Med. Journal, ii., 1878, 919.

<sup>4</sup> Thèse de Paris, 1879.

<sup>5</sup> Thèse de Paris, 1885.

<sup>6</sup> New York Med. Journal, xxxi., 1880, p. 244.

face presents the bright scarlet color that resembles that of a boiled crab or lobster. At the end of this period the resemblance may be made perfect by the appearance of the "strawberry tongue." Up to this point, in default of a knowledge of the patient's idiosyncrasy, the diagnosis may remain impossible. Rarely it remains so throughout the attack, especially when the ingestion of the cinchona preparation is continued. Usually, however, after thirty-six to forty-eight hours the type of normal scarlatina is departed from. The fever rapidly decreases; the angina, which has never been proportionate to the other symptoms, disappears, and the rash either begins to fade or to acquire features unlike those of true scarlatina. It becomes duller in color, more papular in character, and often shows a tendency to form miliary vesicles. Eventually, it may come to resemble ordinary "prickly heat." Such a course, however, is by no means always pursued, and the scarlatinoid features are preserved. In either case, a copious desquamation is sure to follow. This is usually lamellar and may show a glove- and slipper-like exfoliation of the epidermis of the hands and feet. Even albuminuria has been known to add to the embarrassment of the diagnostician. The writer has several such cases in mind and is convinced that a closer scrutiny will lessen the number of cases of so-called "idiopathic scarlatiniform erythema," of "septicæmic scarlatiniform rash," and of isolated "surgical scarlatina," by enabling the observer to assign them to their true cause.

The foregoing considerations would seem to justify the following conclusions:

1. Unprotected persons who have suffered injury, or who have undergone surgical operations, are rather more liable to scarlatina than the unprotected healthy. This increased liability is probably due to diminished power of resistance from disease, and will probably hold with regard to other specific fevers. Scarlet fever is more apt than the other exanthemata to attack such persons, because its influence is usually more widespread, and because it varies within such wide limits that it often escapes the attention of those who readily detect other infectious disorders, and provide against them.

2. When an epidemic tendency of the symptoms we have been considering to prevail after injuries and operations is shown, it may be concluded with confidence that true scarlatina is present.

3. Septicæmia is occasionally accompanied by a scarlatiniform rash which does not depend upon the scarlatinal poison.

4. Medicinal eruptions, especially those from cinchona and its preparations, not infrequently follow injuries and operations. These rashes are probably for the most part usually attributed to true scarlatina or septicæmia.

In obstetrical practice, scarlatina is unquestionably capable of exert-

ing a most noxious influence, but as the distinctly scarlatinal symptoms are here decidedly less important than the obscure and dangerous systemic symptoms that the virus seems to induce, the writer does not presume to enter upon the discussion of this branch of the subject before this Association. He inclines strongly to the opinion, however, that in so far as concerns a distinctly scarlatinal rash in these cases, the line of argument followed in this paper is equally applicable.

19 CATHEDRAL ST., BALTIMORE.

---

### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

THE TENTH ANNUAL MEETING, HELD AT GREENWICH, CONN.,  
AUGUST 25, 26, AND 27, 1886.

*Wednesday—Morning Session.*

THE Association was called to order at 10 o'clock by the President, DR. EDWARD WIGGLESWORTH, of Boston, who delivered the opening address, of which the following is an abstract:

GENTLEMEN:—Just ten years ago, at Philadelphia, I had the honor of calling to order the first public meeting for the organization of this Association. Our specialty for the first time received national acknowledgment. Our guerilla warfare was over, and our subsequent record has been one of unbroken successive victories over bigotry, error, and ignorance.

But the day of paladins is past, and our ranks will admit more recruits. There are still remaining opportunities for more extended instruction of students in medical schools, while the lack of hospital facilities for the proper clinical treatment of diseases of the skin is a standing shame and disgrace to our municipal authorities, our hospital boards, and to the medical profession itself. As now arranged nearly everywhere amongst us, these institutions refuse to a large class of sick persons the benefit of hospital residence either wholly, or offer them, if received, not, we may fairly say, the best medical skill it is in their power to procure. Some progress has, however, been made. New York has now a special hospital for skin diseases, besides two wards in the Charity Hospital, and Philadelphia has special clinics, with beds at three different institutions.

That the workers are ready as soon as they shall have opportunity is evident. Ten years ago, our officially recognized representatives were four professors, five clinical professors, one instructor, and six lecturers;



total, sixteen. To-day, we number seventeen professors, eleven clinical professors, six instructors, and sixteen lecturers; total, fifty. Nor do I include genito-urinary surgery, which I regard as a distinct specialty from that of dermatology, which, of course, includes syphilis.

About twice as many cases of diseases of the skin are now annually treated by specialists as there were ten years ago.

The contributions to American dermatological literature during the past decade include the best treatises, hand-books, and atlases, the only periodicals, and some of the best monographs of the time in the English language.

Our sole local organization, the New York Dermatological Society, is as active as ever, and the good work which it has already done is constantly increasing.

Two honorary and three active members of our original Association have passed away since its organization. Twelve active members, all living, have been added to its ranks. So much for our material progress and present prosperity.

Other objects of the foundation of our Association have been by no means neglected during the past ten years. There exists to-day a harmony and good feeling amongst us which, but for the personal acquaintanceship resulting from the formation of this Association, never would have existed. We have come into better accord as to the "nature and treatment of skin diseases." Our increased membership proves that our Association is "held as a place of aspiration;" and it has consistently required "independent work in our department" as the essential preliminary step toward the acquisition of such membership. The systematic work of our standing committee upon statistics has already furnished valuable data for comparison, as well as a series of excellent reports upon "Leprosy in America." Concerted official effort has done much, and will do more, to repress the rank luxuriance of growth of dermatological nomenclature, and to furnish a "uniform and simple system."

While much has been accomplished, much still remains to be done. The idea of specialism, already rooted, is to be nurtured and trained in the minds of the profession and of the public, and the practical development socially of our specialty itself is to be elaborated in many minor details. The pioneer must no longer prove a martyr. A knowledge of the weaker side of human nature, useful for selfish financial ends, must no longer be allowed to usurp the province of exact scientific acquaintance with disease, inuring to the benefit of our race. The "elaborate division of labor" is "as useful and successful in a learned profession as it is in the mechanic arts." For it is merely a relative question of height of standard. Specialism substitutes quality for quan-

tity, which substitution is the essential characteristic of the civilized man as distinguished from the savage, while the rapidity of such substitution gauges the progress of civilization itself. Medicine is merely that complex whole which results from the combination of all its component parts, and their individual advancement is the criterion of its own progress.

Science is only exact knowledge. Medicine is that knowledge specially directed to the physical welfare of mankind, and specialism is only that further subdivision rendered necessary by the very various parts composing the individual, and possibly by the extension of our opportunities for studying these parts due to increase of mechanical means for enlargement of the fields of our hitherto unaided senses. No one can to-day "take all knowledge to be his province." Science does not culminate in a Jack-at-all-trades, least of all in one whose conscience has become anæsthetized by custom, who confounds his own limitations with the "limitations of human understanding," and his own ignorance with "the immaturity of medical therapeutics." The specialist builds his own boundary wall, and cannot, if he would, poach upon the preserves of others. He "distinguishes what he can do from what he cannot," thus filling the old definition of the best physician. He cannot maltreat a patient, and when compelled to confess ignorance and seek superior wisdom, charge the wronged sufferer another and still higher fee for a "consultation," which is in reality a confession. It has been sarcastically called "the sole duty nowadays of the family doctor is to decide what specialist shall be summoned." It certainly is his duty, and a very important one, as a man of honor to decide whether any one, and, if so, who can probably accomplish that wherein he admits that he himself has failed. Unfortunately, many know so little that they are even ignorant of how much is known by others; but, in many respects, the specialist has already raised the average standard of requirement for general practice to such an extent that much of the old routine practice of physicians who treated their patients for the very diseases for which they referred members of their own families to the specialist, has now become punishable mal-praxis. But the general practitioner has his revenge in opposing as unnecessary the hospital appointment, and even the private practice of the very specialist to whom he himself flees as "a very present help in time of trouble."

We are told that "the human body is made up of parts and functions so thoroughly independent that it cannot be parcelled out into defined and isolated regions." It can, and it cannot. What scientist divides a country into square miles, and attempts to become thoroughly conversant with every atom existing in each of those miles? The special divisions of study are rather the flora, the fauna, the geological strata,

etc., though all these may pervade identically every mile of the region. If regional surgery is possible, then specialists are certainly not contra-indicated. We hear of "appalling pathological conglomerates" due to lack of proper "general medical treatment." Not only "conglomerates," but often single lesions are very variously diagnosticated by different general physicians, and the "conglomerates" are usually merely the aggregated effects of original causes which might have been obviated by proper investigation in due season on the part of suitable specialists.

The aforesaid "consulting physician" meant one who, in addition to his general acquirements, knew more about some particular thing than any one else. We may be sure that his general acquirements had to pay the penalty. To-day we honestly admit this, and, renouncing the practice obtainable by general acquirements, keep to that particular thing of which we know more than others. No one has mental ability enough at the present time to add to the greatly extended knowledge necessary to the general physician the intensified fundamental acquaintance with details needed by the specialist. Life is too short for the ablest intelligence to exhaust even any one specialty. The physician may, like Newton, "think the thoughts of God after Him," but the thoughts of the Infinite upon the smallest molecule of matter call for more than the limits of a finite existence. The true consulting physician of to-day is the specialist, and he should, therefore, receive this title at the hospitals with which he is connected, while those ex-physicians called consulting, but never consulted, should receive their true and proper title of emeriti.

But enough of the "idea of specialism." The public will in time appreciate the absurdity of being content with inferior results in one branch of medicine because, forsooth, there are so many others in which their medical adviser is equally or more at home. It will reason rather that he who "insists upon doing the work of ten men manifests a quality of mind which we can only call arrogance, and which challenges for his work severe criticism." Versatility will not atone for crude and imperfect work, any more than will lack of time, hurry of life, keenness of competition, or financial necessity, and it is merely brazen self-assertion which delights "not so much in doing the thing well as in showing how well he can do it."

Believing in the ultimate achievement of all possibilities and in the progress of truth, I have no doubt as to the future of specialism, if we are honest and earnest. Not infinite omniscience, but infinite morality is the duty of the specialist, and this, conscientiously carried out, will blunt the sharpest dart of the hostile general practitioner. While visions of what yet remains to be accomplished might well lead us almost to despair, a mere glance at the generally prevailing ignorance on the part

of both physicians and their patients shows conclusively that we and our work are imperatively demanded.

Dr. Wigglesworth next considered in detail the duties, in the future, of members of the Association as to the establishment of special skin wards in all general hospitals; as to a revision of the existing nomenclature and classification of skin diseases; as to improvements in the annual reports of transactions; the use of the metric or international decimal system; more extended statistics; the establishment of a permanent committee upon new remedies; the question of fees and the remuneration of physicians by others of the same profession; the desirability of a (proposed) consistent schematic plan for the report of cases, always accompanied by a summary; and the duties of specialists as to instruction. Attention was called to the proposed union of all the special medical associations of America into a general "congress of physicians."

The meeting was then declared open for business.

DR. EDWARD BENNET BRONSON, of New York, read the first paper, which was entitled:

#### ERYTHANTHEMA SYPHILITICUM.

He reported the case of a syphilitic patient who developed a peculiar eruption on the head, hands, and feet. This presented no pronounced syphilitic characteristics, but it was shortly followed by well-marked specific efflorescences on various parts of the body. The eruption on the head subsequently presented infiltrations distinctly syphilitic. The first appearance of the eruption was in the form of an erythema with a vesiculopapular efflorescence. These subsequently broke, discharging a foul-smelling liquid. Later, vegetating growths, resembling condylomata, made their appearance upon the face. In the course of a week or two, the erythematous patches exhibited a copper-colored infiltration. The patient showed other manifestations of syphilitic disease, which rapidly yielded to mercurial treatment. The preliminary eruption in this case was thought to be an erythanthema dependent upon the specific disease. Its origin is probably similar to that of certain angio-neurotic affections, which it closely resembles. The erythanthema syphiliticum is only an indirect effect of the syphilis, the result of reflex irritation of the skin from the action of the disease upon the nervous centres. It is, therefore, not pathognomonic of syphilis.

#### DISCUSSION.

DR. I. E. ATKINSON, of Baltimore, said that, while he had seen similar eruptions in syphilitic subjects, they had never occurred in the early stages, but as manifestations of late syphilis and in malignant cases.

DR. JAMES C. WHITE, of Boston, said that, while *à priori* there was



nothing against a causal relation between the eruption and syphilis, the connection had not been proven, and that, in the present state of knowledge, it was better to regard the association as accidental.

DR. F. B. GREENOUGH, of Boston, remarked that the syphilitic roseola was distinguished from all other forms of congestion of the skin by the presence of little points of congestion which represent the follicles. These show for a long time after all congestion has disappeared. The points of pigmentation seen in this form of eruption also are peculiar. The condition seen in the case described was not a common one; and, whether it was due to the syphilis or not, the co-existence of the two is interesting.

The paper was further discussed by DRs. R. W. TAYLOR, A. R. ROBINSON, and G. H. TILDEN.

The next paper was presented by DR. I. E. ATKINSON, of Baltimore, on

#### RUBELLA OR RÖTHELN.

The author gave an elaborate account of the natural history of the disease, as he had been able to study it from an examination of the reported cases. He referred to the confusion in the nomenclature, and suggested that this affection be termed rubella. For popular use, the expression "epidemic roseola" might be employed.

In discussing this paper,

DR. E. B. BRONSON, of New York, favored the use of the term rubeola to describe this affection, while morbilli was used to indicate measles.

THE PRESIDENT stated that, several years ago, he had proposed a similar nomenclature, morbilli being used to represent measles, rubeola, or rötheln, to represent what is known as German measles, and roseola to represent the simple rose spots as seen in syphilis and other affections.

DR. JAMES C. WHITE, of Boston, objected to the term rubeola being used to describe German measles, because many English and German writers applied this term to measles. He favored the introduction of the new term "rubella."

DR. G. H. FOX, of New York, presented the report of

#### A CASE OF LYMPHADENOMA (MYCOSIS FONGOÏDE); WITH AUTOPSY.

During the summer of 1881, the patient suffered with general pruritus, which subsequently passed away. Small flattened tumors appeared in the axillæ one year later. The eruption disappeared from these situations and reappeared in other portions of the body. Shortly after her last confinement in February, 1885, a tumor developed over the left scapula.

The patient came under observation six months later, and at this time presented numerous lesions, some of which were ulcerated. The most marked lesions were upon the breasts. Treatment with Fowler's solution and with chaulmoogra oil produced no effect, and the patient

died in April, 1886. The autopsy was made by Dr. A. R. Robinson, who gave the results of his examination.

The next paper was

A NOTE RELATIVE TO THE BULLOUS ERUPTIONS PRODUCED BY IODIDE OF POTASSIUM.<sup>1</sup>

By JAMES NEVINS HYDE, M.D., of Chicago.

DR. R. W. TAYLOR, DR. J. E. GRAHAM, and DR. I. E. ATKINSON reported similar cases in which the use of iodide of potassium had produced a bullous eruption of severe type. In all cases the eruption disappeared when the use of the drug was stopped.

---

*Evening Session.*

DR. R. W. TAYLOR, of New York, read the first paper, entitled:

PRECOCIOUS GUMMATA.

The speaker described numerous cases which he had studied, and as the result of his investigations he had formed the following conclusions:

1. Like affections of the osseous system, of the nervous system, and like malignant syphilides in general, the gummata syphilitica may be precocious in appearance, occurring as early even as the second month of infection, but usually in the third or fourth month, and beyond that time.

2. Of the precocious gummatous syphilide or gummata, there are three quite clearly marked forms: *a*, the early, general, and copious form; *b*, the more localized form, which may invade several regions, is usually symmetrically distributed, and sometimes even is confined to one region, particularly one side of the face or scalp, and the roof of the mouth; and *c*, a form in which more or less severe neuralgias precede and accompany the eruption, which in many particulars resembles simple erythema nodosum, but which in its etiology is not in any way related to this simple form of eruption, but is a direct outcome of the syphilitic diathesis.

3. That these precocious gummata partake in general of the features of those of a later period, but they differ in the more acute invasion, in a much more rapid course, and are usually not as profound and destructive in their action as the classical eruption.

4. That of these precocious forms of gummata there are found to be two varieties—one a non-ulcerative or resolute, the other an ulcerative variety.

5. That in the treatment of these precocious syphilides, a combination of mercury and iodide of potassium is much more efficacious than is mercury alone.

<sup>1</sup> Will be published in subsequent number of this JOURNAL.

DR. F. B. GREENOUGH, of Boston, followed with an article, entitled:

CLINICAL NOTES ON SCABIES.

The speaker had been surprised at the increased frequency with which the disease presented itself in recent years. While in 1879 he had seen but three cases, yet in 1885 two hundred and seventy-six cases had come under his cognizance. The ratio of cases of scabies to other affections of the skin had increased from three-tenths of one per cent in 1876 to thirteen per cent in the past year. This rapid increase in the number of cases of this affection was explained by the fact that it was often not recognized, and every case not diagnosed proved a focus of contagion for a large circle of cases. The author had found typical burrows in but a few cases. In male subjects, typical lesions are frequently found on the penis, when not seen in other parts of the body. In the treatment, he had obtained perfect results with sulphur ointment.

DR. A. R. ROBINSON suggested as an aid in the diagnosis that the contents of a vesicle be examined with the microscope. The detection of young acari or of the fæces would at once determine the nature of the eruption.

DR. E. B. BRONSON, of New York, in speaking of the treatment, stated that he had used a fifty-per-cent preparation of naphthol, making one thorough application, with satisfactory results.

DR. H. W. STELWAGON, of Philadelphia, presented a paper on

THE VALUE OF RESORCIN, ICHTHYOL, AND LANOLIN IN CUTANEOUS DISEASES,

giving his clinical observations on the use of these drugs. Resorcin had been found of service in tinea sycosis. In seborrhœa, it had always been found beneficial. In one case of superficial epithelioma of the nose, the use of a fifty-per-cent ointment had been followed by healing.

In three cases of furunculus, ichthyol in the form of a twenty-per-cent plaster had acted with good results. In a small proportion of cases of rosacea and acne vulgaris, it was beneficial.

Lanolin was recommended as an ointment base where a certain degree of penetration was desired. Where, however, simply a protective influence is desired, it is less sufficient than other preparations. In a few cases of acute and subacute eczema, lanolin had produced irritation.

---

*Second Day—Morning Session.*

TROPHONEUROSIS OF THE SKIN CAUSED BY INJURY OF THE MEDIAN NERVE.<sup>1</sup>

By G. H. TILDEN, M.D., of Boston.

<sup>1</sup> See this JOURNAL, page 289.

DR. JAMES C. WHITE, of Boston, read a paper on

NATIVE PLANTS INJURIOUS TO THE SKIN,

in which he gave a detailed description of fifty or more species which were capable, when brought in contact with the skin, of producing irritation varying from a slight erythema to a severe dermatitis.

The paper was discussed by Drs. Sherwell, Piffard, Morrow, Atkinson and Deanslow.

DR. H. G. PIFFARD, of New York, presented a paper, entitled:

NOTES ON DRUGS,

giving his observations on a few preparations recently recommended in the treatment of cutaneous diseases.<sup>1</sup>

A FEW ADDITIONAL NOTES ON PSORIASIS.

By DR. F. B. GREENOUGH, of Boston.

The paper was a continuation of the tabulation of cases which he had presented to the last meeting of the Association. Further observation had confirmed him in the conclusions which he had then presented. He laid special stress upon the good general health of patients who had come under his notice suffering with psoriasis. He had seen twenty-nine cases out of 1,220 cases of all kinds of skin affections, making a percentage of a little over two and one-third. In estimating the general health, he had marked the patients on a scale of five. The average of the general health of the twenty-nine patients thus examined was four and one-third.

DR. A. R. ROBINSON, of New York, reported a case of

CHONDROMA OF THE UPPER LIP.<sup>2</sup>

The next paper described a case of

KERATOSIS FOLLICULARIS, ASSOCIATED WITH FISSURING OF THE TONGUE AND LEUKOPLAKIA BUCCALIS.<sup>3</sup>

By P. A. MORROW, M.D., of New York.

---

*Evening Session.*

A CLINICAL STUDY OF SCLERODERMA.<sup>4</sup>

By J. E. GRAHAM, M.D., of Toronto.

<sup>1</sup> See page 293.

<sup>2</sup> Will be published in a subsequent number of this JOURNAL.

<sup>3</sup> See the JOURNAL for September.

<sup>4</sup> Will be published in subsequent number.



DR. L. N. DENSLOW, of St. Paul, in discussing the paper, related a case of scleroderma affecting the chest, in which benefit had followed the daily use of the constant current, continued for six months.

#### CARCINOMA CUTIS.

By LEGRAND N. DENSLOW, M.D., of St. Paul.

The speaker related a case of this affection occurring in a man aged 49 years. He exhibited a plaster cast and drawing showing the condition.

DR. I. E. ATKINSON, of Baltimore, read a paper on

#### SCARLET-FEVER AND SCARLATINIFORM ERUPTIONS FOLLOWING INJURIES AND OPERATIONS.<sup>1</sup>

DR. P. A. MORROW, of New York, remarked that an eruption simulating that of scarlet fever was frequently produced by antipyrine, although, as a rule, it more closely resembles measles. Antiseptic dressings, such as those containing carbolic acid or iodoform, may produce a general scarlatiniform eruption. Reference was also made to the eruption which frequently makes its appearance on the skin of sensitive individuals, especially females, when exposed for examination. This has been termed "doctor's rash."

DR. L. N. DENSLOW, of St. Paul, related the case of a young woman in whom exposure of the skin to sun-light always produced a scarlatinal eruption. This had been carefully tested and found to be the case.

---

#### *Third Day—Morning Session.*

DR. J. E. GRAHAM, of Toronto, exhibited the specimens from a case of ainhum affecting the toe.

#### REMARKS AND QUERIES IN REGARD TO THE RELATIVE FREQUENCY OF MOLES, AND THEIR PATHOLOGICAL CHANGES ON THE FACE.<sup>2</sup>

By S. SHERWELL, M.D., of Brooklyn.

In discussing this paper, DR. I. E. ATKINSON, of Baltimore, suggested that the prevalence of these growths upon the face might be only apparent, for, in this position, relief is sought for cosmetic reasons, while if the growths occupy portions of the body which are covered, they do not attract attention.

DR. J. C. WHITE, of Boston, thought that these growths were not more frequent on the face than on other portions of the body, but he agreed that when on the face they are much more liable to undergo malignant degeneration.

DR. R. W. TAYLOR, of New York, indorsed the remarks of the reader of the paper with reference to the danger attending the existence of these growths in individuals beyond the age of forty-five years. He also spoke of the danger of malignant degeneration connected with the

<sup>1</sup> See page 295.

<sup>2</sup> Will be published in a subsequent number.

presence of inflammatory masses on the prepuce in old persons. In all cases these should be removed.

In the absence of the author, the Secretary read a paper describing a case of

EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA ?), WITH BULLOUS LESIONS.<sup>1</sup>

By W. A. HARDAWAY, M.D., of St. Louis.

Dr. G. H. TILDEN, of Boston, reported a case of

PROBABLE TUBERCULOSIS OF THE SKIN,

occurring in a child two years of age, who, six months later, developed caries of the vertebræ.

THE TREATMENT OF ACNE BY THE USE OF SOUNDS.

By DR. L. N. DENSLOW, of St. Paul.

At the last meeting of the Association, the speaker had read a paper with this title. He wished now to give a further report of the cases then related. Five cases had been described, four of these, all adults, had remained well. The fifth case, a boy aged 14, had relapsed.

The officers for the ensuing year are as follows:

*President*, H. G. PIFFARD, M.D., of New York.

*Vice-Presidents*, F. B. GREENOUGH, M.D., of Boston, and R. B. MORISON, M.D., of Baltimore.

*Secretary*, G. H. TILDEN, M.D., of Boston.

*Treasurer*, LEGRAND N. DENSLOW, M.D., of St. Paul.

A committee, consisting of the above-named officers, was appointed to confer with committees from other societies with reference to the organization of a congress of American physicians and surgeons.

The selection of the time and place of the next meeting was left to the Council.

The Association then adjourned.

**ANOTHER HERMAPHRODITE.**—Among the replies to an advertisement of a musical committee for "a candidate as organist, music-teacher, etc.," was the following one: "Gentlemen—I noticed your advertisement for an organist and music-teacher, either lady or gentleman. Having been both for several years, I offer you my services."—*Exchange*.

<sup>1</sup> Will be published in a subsequent number of this JOURNAL.

## Correspondence.

---

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

#### Late Hereditary Syphilis—Fournier.

I CANNOT refrain, in beginning this letter, from calling the attention of my American confrères to the new work just published, from the pen of the eminent professor of dermatology and syphilography of the Paris faculty, M. Fournier.

I do not believe that there exists another treatise on the subject so complete in all respects. It will be impossible for me to give an analysis of the work at this time. It contains, first of all, carefully detailed, all the practical methods by which late hereditary syphilis is to be discovered in children and adults when a history is wanting. It is not necessary for me to dwell upon the practical importance of diagnosis under these conditions. Again, the author describes with care the phases of the disease more especially observed in late hereditary syphilis, and ends with a comparative table of acquired syphilis of infancy. I cannot praise too highly the clearness of style and the originality of certain chapters which contain descriptions entirely new. "

#### The Relations Existing Between Lupus and Tuberculosis.

This eternal question is being always agitated, and still we advance but slowly towards a solution.

Prof. Leloir has been able, by his activity and scientific ardor, to create at Lille a dermatological centre, the influence of which is already manifest. He has just published a new memoir on the subject of lupus and tuberculosis in the *Annales de Dermat. et de Syphil.* He there relates a case in which he has seen "in the clearest way a lupus nodule of the hand become the origin of tubercular lymphangitis with the production of scrofulo-tubercular gummata along the course of the implicated lymphatics, and finally determine, by absorption of the tuberculous virus through the lymphatics of the upper extremity, a pulmonary tuberculosis of the corresponding side." It must be further remarked that in certain cases erysipelatous lymphangitis seems to play an important part in the absorption of tubercular virus. Its appearance is followed, after a longer or shorter lapse of time, by engorgement of the cervical ganglia. Then local and general phenomena supervene, indicative of a deposit of tubercle in the apex of a lung or in some other organ.

Out of eight women suffering from lupus whom the author treated in his service at the St. Sauveur Hospital, five presented incontestable phenomena of pulmonary tuberculosis; of nine men attacked with lupus, five were equally affected with the signs of tubercular deposit in the lungs. Dr. Leloir has further had occasion to examine histologically two cases of well-marked tubercular lupus in non-tuberculous subjects, and he has found (out of a large number of specimens, to be sure) a few scattered tubercle bacilli. Fragments of this lupus tissue introduced into the peritoneal cavity of guinea pigs furnished a series of incurable tuberculosis in six cases. He therefore concludes that true lupus vulgaris is one of the forms of cutaneous tuberculosis.

### Treatment of Lupus Vulgaris.

It is well known that at the St. Louis Hospital in Paris two principal methods of treating lupus vulgaris are in vogue. Dr. Vidal employs the surgical method, and more especially the quadrilateral linear scarifications, which, carried out on the principles which he has so forcibly laid down, give, in many cases, results which are truly marvellous, especially in regard to the regularity of the cicatrices. Dr. Besnier, on the contrary, accuses these bloody methods of favoring the general infection of the economy with tubercular virus, and uses only the electro- or galvano-cautery. For my own part, I have practised scarification in private practice and at the hospital in many cases of lupus, and up to the present time have seen no greater rapidity in the evolution of tuberculosis in the cases so treated than in those left to themselves. I am still looking for a case of pulmonary tuberculosis developed in a lupus patient treated by scarifications. I cannot therefore believe in the noxious influence of the scarification treatment of this disease until more amply informed.

The more carefully I look into the matter, the more convinced I become that it is quite often necessary to combine the methods of which I have spoken, in order to effect a cure. This is how I usually proceed with a case. I begin by making a series of linear scarifications, then cross them at right angles, repeating the operation every eight days, and in the intervals I apply to the patches of lupus the *emplâtre de Vigo cum Mercurio*. Very rapid amelioration is thus obtained, but the amelioration after a time is lessened, and I then practise one or two cauterizations with the electro-cautery. In the great majority of cases, the modification of the disease procured is considerable; I then return to scarifications, and so on.

Cauterization is most useful when we have arrived at that period of the disease which in France we call the period of isolated tubercles, that is to say, when there exist small yellowish tubercles disseminated here and there in the cicatrix. We touch them then one by one with the fine red point of the electro-cautery or of the galvano-cautery. In following this mixed method, we obtain much more rapid amelioration than by the method of scarification alone, and I believe cicatrices are better formed than when the cautery alone is used. It is well to wash the part operated upon from time to time with a solution of corrosive sublimate one to a thousand, and to give arsenic internally. I have tried and am still trying in lupus vulgaris applications of salicylic and of pyrogallic acids in collodion (one gram of salicylic acid and five grams of pyrogallic acid to fifty grams of flexile collodion). The effects produced seem to me irregular. The inflammation produced is often too great and too long continued, and in consequence ulcerations are produced which are long in healing, and still the tubercles have not been destroyed so deeply that they are not reproduced. Nevertheless, I cannot forget that Drs. Vidal and Besnier in France and several German dermatologists have obtained quite good results with pyrogallic acid in ointment or plaster, and I intend to follow out my trial of collodion dressings.

### Treatment of Erythematous Lupus.

What I can affirm at the present time is, that the collodion of which I have just spoken has given me good results in erythematous lupus, particularly in an old woman who had had for more than twenty-five years an erythematous lupus of the forehead, nose, and face. Care must be exercised over the action of this



drug, and it must be carefully watched. A new layer should not be painted on, and the old one should indeed be removed whenever pus is seen to form between the integument and the dressing. Neglecting this precaution, we may have a very intense inflammation, causing the patient much pain, and producing deep ulcerations. I do not believe that there is one medication which alone can be recommended to the exclusion of all others for erythematous lupus. In determining the respective worth of the various methods of treatment already known to deserve serious consideration (such as pyrogallie acid, pyroligneous acid, vinegar and acetic acid, emplâtre de Vigo, black soap, and scarifications), we must take into account individual susceptibility. One patient will obtain no benefit from the use of the soap, but will at once begin to improve when scarification is begun, and inversely. We should therefore not persist in employing a method which appears to have but little beneficial effect. It happens at times that after using with much success for a period one of the methods mentioned above, the amelioration slackens little by little until it becomes almost imperceptible. If now we persist in using the same treatment, the affection resists, and finishes by tiring out the patience of the patient and of the physician too. As soon as this diminution in the progress of the cure is noted, we must resort to the other means at our disposal, and among them we are sure to find one which will act beneficially. The period of favorable action having passed—and this is very variable according to the subject and the method—we can come back to the first treatment employed which will usually again give excellent results.

I am convinced, for my part, that scarifications made to cross, and as near to each other as possible, constitute the best possible treatment that we have against this affection, but I also believe that in many cases, if this is the only treatment, and is continually employed, a positive cure can, with difficulty, be effected. The cure will be easily obtained, on the contrary, if we cease for a time the scarification to employ some other method. Besides, scarification is not always possible, either because the patient cannot secure the services of a specialist, or because he is unwilling to go to the expense, or because the disease is too extensive, and it is for this reason that I have recently recommended in the treatment of erythematous lupus the mixture of yolk of egg and vinegar.

This is used either as an application made with equal parts of fresh yolk of egg and ordinary vinegar, and allowed to macerate for twenty-four hours, or a paste is made of the hard-boiled yolk triturated with vinegar, and macerated for several hours. Acetic acid may be added if necessary, if it is found that this paste is not strong enough. The consistence should be such that it can be spread easily on flannel without running; it is to be applied during the night to the affected part. I have in no wise endeavored to find in this topic a specific for erythematous lupus, but regard it as a practical, convenient treatment, free from danger, and one whose effects can be graduated at will by the addition of acetic acid, so as to obtain the degree of inflammation necessary. The patient can employ it without fear in the absence of the physician, and can alternate it with applications of black soap plaster; applications which, to my mind, furnish the most energetic method of treatment after the quadrilateral linear scarifications. After this application has been made for some time, it can be replaced with black soap plaster, to be applied again. It will be found that this interruption of the egg and vinegar dressings renders them more efficacious when begun again.

This method has the further advantage of being so cheap that it is within the

reach of all. It is well understood that, should inflammatory manifestations become too violent, the dressings are to be suspended, and potato-starch poultices applied cold, or vaseline smeared over the part until treatment can be continued.

The following is the treatment I have seen Dr. Besnier employ in erythematous lupus: He first scrapes the diseased portion with the sharp spoon, then he makes repeated cauterizations of the scar tissue with the solid stick of nitrate of silver, and finally passes over it with a stick of zinc. He finds that this treatment brings about a rapid cure. I fear, however, that the cicatrices thus obtained are not so perfect as those formed after the methods of which I have just spoken.

### Treatment of Superficial Epithelioma.

The author just mentioned has treated superficial epitheliomata for some time with the electro-cantery, being careful to pass beyond the limits of the disease, both on the surface and in the deeper parts. He then applies a simple dressing until complete cicatrization. Dr. Vidal has, for a long time, been in the habit of scraping out these epitheliomata and, after carefully removing all tissue that would break down under the curette, to cauterize the wound with pure pulverized chlorate of potash, and subsequently dress with tarlatan soaked in a concentrated solution of the chlorate of potash. I have obtained several remarkable cures in this way. I cannot understand why it is that this treatment has not become more common, and is not more employed in France.

### Treatment of Syphilitic Phagedenism.

Dr. Vidal has very recently found another application besides the chlorate of potash. There was in his service at the St. Louis Hospital in Paris a young man who was greatly addicted to the use of alcohol, and who had contracted syphilis some months before. Notwithstanding the general treatment which he had received, the cutaneous lesions did not heal, but presented a bad appearance, ulcerated, and became phagedenic. They extended both upon the surface and in depth, with great rapidity. Emplâtre de Vigo, red plaster (containing minium and cinnabar), iodoform, etc., not having any effect, Dr. Vidal conceived the idea of dressing the ulcerations with powdered chlorate of potash first, and then with absorbent cotton soaked in concentrated solution of chlorate of potash, and covered with adhesive plasters. The phagedenism was arrested, and the patient got well. It is true that since then Dr. Vidal has unsuccessfully tried the chlorate of potash in the simple phagedenic chancre. Pyrogallic acid gives him the best results in the latter affection.

In an article which appeared in the *Annales de Dermat. et de Syph.*, Dr. Spillmann remarks that phagedenism, whether it occur on syphilitic lesions or simple chancres, is in great part due to a peripheric infiltration of new elements, and of colonies of microbes which compress the vessels, and thus cause a loss of vitality in the tissues. He has succeeded in stopping this process by destroying this zone of infiltration with the sharp spoon or cutting curette, then excising the loosened borders with curved scissors, cauterizing with the thermo-cautery, and dressing with corrosive-sublimate solution. He thus transforms the serpiginous, fungous, gray-colored lesion of phagedenism into a well-conditioned wound, capable of rapidly healing.

### Treatment of Melanodermata.

Prof. Leloir, of Lille, gives, in the *Journal de Connaissances Méd.*, July, 1886,

a treatment for melanoderma which has succeeded well in his hands. He has employed it in a large number of cases of pigmentation of various origin, and even in three cases of flat pigmentary naevus (*naevus spilosis*) and in two pigmentary naevi as large as a five-franc piece. In these various cases he obtained a rapid cure. This is the mode of procedure: After having first thoroughly cleansed the part with a soft potash soap, or simply with alcohol, he applies several layers of the following application: chloroform, 100 parts; chrysophanic acid, 15 parts; and when this coat has dried, he covers it with a layer of traumaticine; that is to say, gutta-percha dissolved in chloroform. When the adherent pellicle is detached, a new application is made, and so on.

In two cases of pigmentary naevus, the author has first treated the spots with salicylic ointment, and he thinks thus to have rendered the action of the chrysophanic acid more efficacious. It must be remarked that this treatment can only do good in epithelial melanoderms, and not in those which depend on a deposit in the interior of the derm itself.

L. BROCC.

PARIS.

---

## Selections.

---

### THE INTERNAL TREATMENT OF GONORRHOEA.

At the meeting of June 21st, of the Berlin Society of Internal Medicine, a discussion arose upon the treatment of gonorrhœa by medicines.

Dr. Posner stated that, although what had been learned about the gonococcus was extremely interesting, it had not given us much that was practical so far as treatment was concerned.

Local anti-bacterian treatment has not yet been followed by brilliant results, and to-day we treat gonorrhœa with the well-known remedies, and combat it especially with the various forms of injection. These injections are not valuable in that they destroy the gonococci, but because they cure the inflammation of the mucous membrane. Internal medicines act beneficially by passing off in the urine and clean out the urethra in the opposite direction from that in which local treatment acts.

He speaks highly of sandal-wood oil, which has had such a reputation in France, and which he has used much because he has become convinced that injections, although they work so well in some stages of gonorrhœa, still are not well borne by many patients, and can indeed act injuriously. From the speaker's observation he believes that many gonorrhœas which would get well of themselves under suitable regime are often kept up artificially.

He has used the sandal wood in fresh cases, and can state from his own observations that under all circumstances it was better borne than the other balsams, and that under all conditions it exerted a better influence on the disease.

In those complications of gonorrhœa in which we have to cease injections, on account of epididymitis, cystitis, prostatitis, etc., this drug is greatly to be recommended.

Repeatedly had Dr. Posner seen cases of acute catarrh of the bladder, with bloody or turbid urine, improve and the urine become clear after a few doses

of the sandal-wood oil. In old cases of cystitis and prostatitis, it is also beneficial and always acts favorably on the tenesmus, and clears up the urine. In chronic gonorrhœa, less stress is laid upon its beneficial action. The purity of the preparation is of great importance. The most elegant form to use is the French preparation which goes under the name of "santal midi," put up in capsules which are easily taken and well borne. The patient takes daily from ten to twelve of the capsules of five drops each. A German preparation on the market, also in capsules, does not agree so well with the stomach. If the oil does not agree with the patient, a little hydrochloric acid may be added to the dose, and, to improve its taste, a few drops of oil of peppermint.

Altogether, according to the speaker's idea, sandal-wood oil is the most efficacious internal remedy at our disposal.

Dr. Lublinski has had occasion to use sandal wood since his attention was called to it from English sources, some four years ago, and he agreed with Dr. Posner as to its value. It does not affect the stomach nearly so much as balsam of copaiba, but its action is not so strong as the latter drug. He has increased the daily dose gradually to twenty capsules. When administered in drops, he gives peppermint tablets with it. In severe tenesmus, even when the bladder is affected, he has found it to work admirably.

Dr. Rosenthal had also used sandal wood, but when a decided result was not obtained, he was better satisfied with the old balsam of copaiba. It is desirable to have the drug remain as long as possible in contact with the mucous membrane of the urethra. When the disease is in the posterior part of the urethra, in the neighborhood of the neck of the bladder, balsam of copaiba has an especially favorable action, but if the gonorrhœa is in its first stage the result is not so good. He does not altogether agree with Dr. Posner that no injections are necessary. That balsam of copaiba has an action on the gonococci is shown by a recent work of Oppenheimer. The gonococcus does not grow when placed in the urine of a man who has been taking the balsam. When gonorrhœa reaches the neck of the bladder all injections must be withheld, and at this time he has found balsam of copaiba the best remedy.

Dr. Caspar also confirmed in all essentials Dr. Posner's observations. He had first learned of the use of the drug in England two years ago, and had since made frequent use of it. He finds, however, the dose given by Posner rather large, and uses himself only a ten-drop dose three times daily. The East India sandalwood is that most to be recommended.—*Deutsche Med. Zeit.*, July 1, 1886.

### ECZEMA OF THE NARES.

IN the July number of this JOURNAL will be found an article on *Excoriationes Narium*, giving the conclusions of a paper by Dr. Schmiegelow. This troublesome affection has deservedly received considerable attention of late, in connection with eczema, suppuration of the interior of the nostril, and allied diseases.

Dr. Kiesselbach has an article in the *Monatsch. für Ohrenheilk*, 1885, No. 2. He says that the external skin of the nose, instead of stopping short at the entrance to the nostril, reaches up to the upper edge of the alæ nasi, and almost to the anterior edge of the lower cartilage and cartilaginous septum; thus diseases of this portion are in reality skin diseases. Eczema of this region, which is the commonest disease met with, depends upon an acute or chronic rhinitis, as a rule, but in its development and course acts entirely like the various forms of eczema found on other parts, excepting that here is rarely to be discovered the outbreak



of vesicles. The continual irritation quickly produces crops of pustules and rhagades soon form. The acute forms get well rapidly upon the disappearance of the exciting acute rhinitis, but if they become chronic they remain most obstinately upon the parts about the floor of the nostril and on the inner walls of the tip of the nose, and occasion various disorders, among which the author especially mentions scrofulous hyperplasia of the upper lip, reddening of the skin of the nose, and predisposition to recurrent erysipelas of the face. As treatment he recommends in the acute form simply some non-irritating fatty protective. In the chronic form, Hebra's diachylon ointment, or white precipitate salve, spread over the parts with the aid of a glass rod.

In No. 5 of the same journal, Dr. Moldenhauer says that we have to deal with two diseases of the entrance of the nostril which are distinctly separate, both pathologically and clinically. 1st. Eczema, which is mostly encountered in children having some signs of scrofula, especially when the surrounding parts about the nostril and lip are implicated, and 2d, sycosis, which occurs as a suppurating folliculitis of the hair sac in the skin of the tip of the nose by preference, while here, even in women, are found thick, stiff hairs.

The treatment given consists in epilation, where it is necessary, puncturing of the pustules, scarification where there is much infiltration of the skin, and the employment of emollient local baths for the nose.

Another article occurs in the same number of the journal mentioned, giving the views of Dr. Baumgarten, of Budapest, who advises in cases where the skin is much infiltrated and covered with thick crusts, to epilate the large hairs and to rub into the part with a pledget of cotton some white precipitate ointment, so as to make it penetrate the skin and cause it to become more pliable.

## **ELECTROTHERAPY IN A CASE OF ANGIONEUROTIC BULLOUS EXANTHEMA.**

DR. VON BREDa reports the following case in the *Giornale Italiano delle mal. ven. e delle pelle*, March, 1885.

A married lady of 23, slightly anæmic, but otherwise healthy, presented an afebrile exanthem, attended with severe pain in one spot, which increased on motion, was neuralgic in character, and extended to the point at which the eruption appeared three or four days later. The painful region now began to swell, and an eruption similar to that in erythema annulare appeared, and advanced from the periphery towards the centre. The pain increased, until finally small vesicles formed at the edge of the affected spot. These soon became confluent, formed a ring of vesicles, and finally a bulla from advancement toward the centre. Such eruptions quickly appeared in great numbers upon the upper and lower extremities.

The galvanic current, with the anode at the back of the neck and the cathode on the affected region, greatly diminished the pain and aborted the attack.

A relapse was treated by the method of Beard and Rockwell: the positive pole on the back and the negative in the water of a lukewarm foot-bath, in which the patient's feet were placed.

## **SYPHILITIC EPILEPSY AND ITS DIFFERENTIAL DIAGNOSIS FROM ORDINARY EPILEPSY.**

1. SYPHILITIC epilepsy manifests itself not only by epileptic phenomena, but by attacks which are such a faithful reproduction of the clinical picture of ner-

vous epilepsy that it is absolutely impossible to differentiate the one from the other.

2. It is not due to a special virus, as was taught twenty years ago, but to cerebral and medullary lesions.

3. It is distinguished from essential epilepsy: 1st. By the absence of the cry or the aura, by the mode of succession or apparition of its crises, by the age of the patient, by the cerebral troubles, precocious or late, preceding or following the attacks (cephalalgia, vertigo, fainting, Jacksonian epilepsy)—all characters of a secondary order as regards this diagnostic value, since they are common both to epilepsy symptomatic of a syphilitic lesion and of an ordinary tumor of the brain. 2d. By the frequent co-existence of disorders of sensation in the limbs, especially the lower limbs, and by the frequent abolition of the tendon reflexes—phenomena which possess a real importance from a diagnostic point of view, since they are wanting in ordinary epilepsy, while they are quite frequent in syphilitic epilepsy; in the latter case, the brain and cord are simultaneously affected by the specific disease. 3d. By the effects of mercurial and iodide treatment.—DR. BARBIER. *Th. de Paris*.

### ZINC OXIDE IN THE TREATMENT OF CHRONIC SPECIFIC URETHRITIS.

DR. BALL, of Albany, speaks highly of the use of zinc ointment in the treatment of chronic urethritis. In fifteen cases in which this remedy was employed, the average duration of the treatment was a little over four weeks; the shortest was ten days, the longest eight weeks. The ointment is made according to the following formula: R Zinci oxid., ʒ iij.; Adipis, ʒ iij.; Cerati simpl., ʒ ij. M.

A moderately sized, olive-pointed bougie is selected; the constricted portion of the bougie is filled out evenly, and as smoothly as possible with the full calibre of the instrument by means of the ointment, which adheres readily. The bougie is carried down to the prostatic portion of the urethra as rapidly as possible, and then, after rotating, it should be slightly withdrawn, and pushed back again. The remaining portion of the urethra should be similarly treated, giving plenty of time for the ointment to be melted, and left in contact with the diseased membrane. The applications should be made at least twice a day, in the morning and just before retiring. The patient should be instructed to empty his bladder previous to the application, and refrain from doing so again as long as possible.—*Albany Medical Annals*, June, 1886.

### CLINICAL STUDY OF MOLLUSCUM PENDULOSUM.

1. MOLLUSCUM is a tumor due to circumscribed hypertrophy of the derma, a sort of local elephantiasis, the fibrous tissue predominating in the derma; the tumor is therefore essentially fibrous.

2. The tumors may be disseminated over the entire surface of the body, or localized in certain points. The first variety may be classed under the term molluscoid diathesis or generalized molluscum; the second variety may be classed as localized molluscum, and is generally pediculated.

3. These two varieties of molluscum, although anatomically allied, should be regarded as absolutely distinct from a clinical point of view.

4. The labium majus and the inguinal crease constitute the seat of predilection of molluscum pendulosum as well as of elephantiasis.

5. The elastic ligature should be preferred to all procedures for the removal

of pediculated tumors. Practically, it is convenient, but slightly painful, does not frighten the patient, and puts at rest all fears of hemorrhage.—DR. M. BARRY, *Th. de Paris*.

### THE EMPLOYMENT OF THE EMPYREUMATIC OIL OF THE YELLOW OF EGGS AS A DRESSING.

REFERENCE has been made in this JOURNAL to Dr. Brocq's treatment of lupus erythematosus with a mixture of vinegar and the yellow of eggs. M. Fremm has employed the empyreumatic oil obtained from the yolks as an antiseptic dressing to ulcers and ulcerous wounds with excellent results.

In one of his cases, three of the ulcers occupied the postero-external region of the middle of the thigh; in three others (a, b, c), the antero-external region of the right thigh; they were all of the same dimension, that of a fifty centimes piece.

May 23, M. Fremm dressed two of the ulcers, a and b, with the empyreumatic oil, the ulcer c with iodoform, the three others with phenic acid, one to forty.

The dressings were renewed every second day. On May 29, after three dressings, the ulcers a and b were partly filled up and almost healed; the ulcer c was reddish, but almost of the same extent as on the 23d; while of the three ulcers dressed with phenic acid, one was slightly improved, while the others were indolent, grayish, and without evidence of reparative granulations.

During six months past, the empyreumatic oil was then daily employed in the military hospital of Bordeaux, in numerous cases of wounds, ulcers, abscess, and also in gonorrhoea, with the most satisfactory results.

The oil is obtained by separating the albumen, and cooking the yolks for forty minutes. The oil obtained is of a brownish color; the odor of burned organic matters, burned horn; the taste (at first slightly sweetish) excessively bitter; syrupy consistence; neutral reaction; density 0.986.—DR. OGER, in *Jour. de Méd. de Paris*, Aug. 15, 1886.

### LEPRA TUBEROSA.

THE following are some of the conclusions of a paper on lepra, from the pen of Unna (*Centralblatt für die Ges. Therapie*, Nov., 1885).

1. Lepra tuberosa is curable.
2. The cure can be effected in a comparatively short time by the energetic employment of reducing agents, internally and externally.
3. Among such agents are especially to be recommended, ammonium sulpho-ichthyolicum (ichthyol), chrysarobin, pyrogallol, and resorcin.
4. Ichthyol must be used externally, in very concentrated form. Internally one gram per day will suffice.
5. Resorcin is a useful drug, rendering good service in form of salve and plaster, and recommended where more powerful agents are contraindicated.
6. Pyrogallol is a powerful drug against lepra, and should only be employed in form of a five-per-cent salve.
7. Chrysarobin is perhaps the most efficacious outward application, but in lepra more than in other diseases, the danger of causing conjunctival irritation prevents its exclusive employment.

## Items.

---

**NOTICE.—THE CHROMO-LITHOGRAPH** designed for the October number, will appear in the November number of this JOURNAL.

**AMERICAN DERMATOLOGICAL ASSOCIATION.**—At its recent meeting at Greenwich, this Association resolved to issue an invitation to foreign dermatologists to attend its meeting next year, and present papers and take part in the proceedings. The meeting will be held early in September, but the time and place have not yet been definitely determined.

**CAN A MAN HAVE A FEMALE COMPLAINT?**—A young man entered the Dispensary of the Chicago Polyclinic recently, and going up to the clerk held out one of the Dispensary circulars, with the question: "Say! isn't this the hour for diseases of women?" The clerk answered in the affirmative, when the young man said: "Well! I've got a disease of a woman and want to be treated."—*Jour. Am. Med. Asso'n.*

**SCIENTIFIC INQUIRY.**—At a local medical meeting a country child of ten der years having an anomalous skin eruption was shown. There was some suspicion that it had a specific origin. An inquirer, more enthusiastic than discriminating, asked the child: "Has your mother ever had any mis-carriages?" "No, sir," she said; "mother has always took around her vegetables in a *donkey-cart*."—*Exchange.*

**MIXTURE TO STOP FALLING OF THE HAIR AFTER TYPHOID FEVER** (Bouchard).—

℞ Ol. Ricini.....	7 grams.
Goudron .....	2 "
Tinct. Benzoini.....	20 "
Chloroformi .....	30 "
Alcohol.....	1,000 "

—*Le Concours Médicale.*

**TREATMENT OF ALOPECIA** (Bartholow).—

℞ Fl. Ext. Pilocarpini.....	1 part.
Tinct. Cantharides.....	1 "
Liniment. Saponis .....	2 parts.

M.

—*Colleg. and Clin. Record.*

**PARASITIC SKIN DISEASES** (Bartholow).—

℞ Picrotoxin.....	grs. x.
Benzoinated Mutton-suet.....	$\frac{5}{8}$ i.

M.

—*Ibid.*

**INCONTINENCE OF URINE** (Bartholow).—

℞ Ext. Ergotæ.....	gr. i.
Ext. Nucis Vomiceæ .....	gr. $\frac{1}{6}$ .
Ext. Belladonnæ.....	gr. $\frac{1}{8}$ .

Fiat Pil. Sig. Take three times a day.

—*Ibid.*







*Dr. Morrow's Case of Favus.*

JOURNAL  
OF  
CUTANEOUS AND VENEREAL DISEASES.

---

VOL. IV.

NOVEMBER, 1886.

No. 11.

---

Original Communications.

---

REPORT OF A CASE OF FAVUS (TINEA FAVOSA), WITH REMARKS  
ON THE TREATMENT OF THE TINEAS.

BY

PRINCE A. MORROW, A.M., M.D.,

Surgeon to Charity Hospital, Dermatological Division.

THE following case of favus is interesting on account of the unusual development and long persistence of the disease.

The patient, an Italian boy, was brought to me by Dr. J. E. Attinelli, Attending Physician to the Italian Class, New York Dispensary, with the following history.

"The boy, Domenico Muccia, æt. 13 years, was born in the town of San File, province of Basiliatica, Naples, and has been afflicted with the disease nine years. Nicola, his father, was twice married; by his first wife he had one son, Fizio, who was placed out to nurse. Several of the children of this nurse were affected with favus which is quite prevalent in this locality, from whom Fizio acquired the disease.

"By the second wife he had nine children, all of whom contracted the disease from Fizio. These children appear to have been cured by epilation and inunctions, with the exception of Domenico. In his case, the disease proved entirely intractable, and the father sent him to New York, to the care of a maternal aunt, in the hope that he might be cured.

"On June 25, he presented himself at the New York Dispensary. A diagnosis of favus was made, and he was referred to Dr. Morrow for advice and treatment."

Upon examination, June 28, the disease was found to be distributed over the head, the left upper arm, the lateral surface of thighs and legs below the knee, and the internal surface of buttocks, near the anus. The patient indicated various other portions of the body which had formerly been occupied by the disease, but from which it had disappeared.

Almost the entire hairy scalp was found to be seat of the disease. Scattered over the scalp were numerous, variously sized, cup-shaped, yellow crusts, the depressed centre of each perforated by a hair.

Over the vertical region there were two or three irregularly shaped coneretions formed by the coalescence of the favi, which still retained their cup-shaped character. The ridgy borders of these patches were elevated one-eighth of an inch or more above the surface, the centres somewhat hollowed.

The hair was quite thin, and in many places, especially over the vertex, there was complete alopecia. The peculiar "mousey" odor exhaled by the crusts was quite pathognomonic. Over the left deltoid region, at the insertion of the deltoid, and on the lateral and posterior surface of the arm extending nearly to the elbow, there were a number of rounded, irregularly shaped concretions formed by the fusion of contiguous scutula, which had lost their distinctive shape, constituting the condition known as *favosa squarrosa*. These concretions were admirably shown in the photograph from which the accompanying picture was made.

The lateral borders of these crusts were firm and unbroken, rising fully one-half an inch above the niveau, and of a clear sulphur yellow. On the surface the crusts were disintegrated, somewhat friable, and presenting the appearance of whitish-yellow mortar.

The patches on lower extremities presented the same general characteristics, but were of smaller proportions.

The patch near the margin of the anus was evidently of more recent development. It was composed of a number of lesions concentrically arranged, which in color and shape were most characteristic.

The patient was sent to Charity Hospital, and the treatment was carried out under the direction of my colleague, Dr. Bronson, who was then on duty.

After removal of the crusts and epilation of the diseased hairs, an ointment of chrysarobin was rubbed into the scalp, and a solution of the bichloride (grs. iv. to  $\bar{z}$  i.) was applied to the patches on the body. The affected surfaces were also ordered to be washed with green soap.

August 10, the following ointment was ordered:  $\bar{R}$  Aëdi salicylici,  $\bar{z}$  ij.; Chrysarobini,  $\bar{z}$  ij.; Pulv. eretæ,  $\bar{z}$  iiss.; Vaselini,  $\bar{z}$  ij. M. Rub in for fifteen minutes at night.

September 5. When my service began, the disease had entirely disappeared from the body, leaving as traces slight pigmentations which mark the seat of the lesions. The hairy scalp is clear, with the exception of one or two small pustules. The region of the vertex is almost completely bald, only a few scattered hairs are seen. Owing to the atrophy or destruction of the glandular structures, the portion of the scalp denuded of hair is thin and glistening, presenting the appearance of a tensely drawn piece of parchment.



October 1. The disease is apparently cured. A dressing of carbolyzed vaseline was ordered, and the patient kept under observation to watch for signs of a possible outcropping of the disease.

The history of the treatment of the class of diseases comprehended under the general term "tinea," through its various phases of charlatanry and empiricism until it came to be established on a scientific basis by Bazin, forms one of the most curious and interesting chapters in medicine.

All rational treatment of the present day has for its object the destruction of the offending parasite by topical means, and varies only in the choice of the agents used, and in the mechanical details of its execution.

In the treatment of tineas affecting the general surface of the body, the treatment is simple and usually promptly efficacious. It consists in the use of parasitocides or irritants which destroy the spores, or cause exfoliation of the epidermic structures in which they find a lodgment.

In the treatment of tineas affecting the hairy regions, more particularly the scalp, the problem is complicated by causes purely physical. Instead of the spores being confined to the superficial epidermis and readily accessible to our remedies, they have penetrated to the depths of the hair follicles and even into the substance of the hairs themselves, and within this secure retreat they vegetate into luxuriant growth and defy dislodgment. The disease is obstinate to treatment on account of the mechanical difficulty of bringing parasitocidal agents into immediate contact with the parasite, to overcome which various measures have been employed.

The treatment of favus and ringworm of the scalp does not differ essentially in principle or detail. The first step is the removal of all crusts or scales from the affected surfaces. This may be accomplished by a thorough soaking with olive or linseed oil, or the application of emollient poultices. After removal of all extraneous matters and thorough cleansing of the affected surfaces with soap and water, the hairs should be cut, either with the scissors or a pair of barber's clippers. The razor should never be used, as, according to Besnier, it is the frequent cause of auto-inoculation.

The next step in the treatment is the extraction of all the hairs in the area of the diseased patches. Although many authorities depreciate the importance of epilation, or reject it altogether as an unnecessary, painful procedure, yet it must be regarded as a most essential part of the treatment, especially in advanced or chronic cases. It subserves the double purpose of removing the mass of spores contained in the diseased hairs, while

leaving the orifices of the follicles open, and thus furnishing a more ready entrance to the parasiticial agent.

For this procedure a good epilating forceps with smooth blades should be employed. The use of the calotte or the epilating sticks is too barbarously painful to be recommended. In ringworm of the scalp, the texture of the hairs is so altered from the abundant infiltration of their substance with the fungus that they easily break off, and frequent repetition of the epilation over the same area may be necessary. In favus the hairs are less brittle and more firmly implanted, so that the process of epilation is less tedious to the physician, but more painful to the patient. It is always well to remove the healthy hairs in a narrow zone immediately surrounding the patches, thus limiting their peripheric extension. In order to accelerate the spontaneous elimination of the diseased hairs by provoking a certain amount of irritation, M. Feulard, in his recent work, "*Teigne et Teigneux*," recommends touching the diseased patches with a little crystallizable acetic acid, pure or mixed with chloroform. The applications are to be made with care and at sufficiently long intervals so as not to cause too much irritation.

Immediately after epilation, the parasiticial preparation should be applied. A vast number of agents have been recommended for this purpose, as bichloride and sulphate of mercury, iodine, naphthol, thymol, acetic, boracic, carbolic, chrysophanic, pyrogallie, pyroligneous, salicylic, sulphurous acids, oil of cade, oil of turpentine, croton oil, etc., etc. Success depends, however, less upon the choice of the agent than upon the thoroughness with which the details of treatment are carried out. Equally numerous have been the preparations employed, as aqueous, alcoholic, ethereal solutions, ointments, oleates, collodion and traumaticin combinations, etc.

One of the most efficient parasiticides is a lotion of corrosive sublimate (one or two grains to the ounce), which may be applied by means of a small brush or a piece of flannel dipped in the solution. At night the scalp should be washed with the tincture of green soap and warm water. Should the treatment provoke pustular or other irritation, it must be suspended and emollient applications, or a lotion of hyposulphite of soda (thirty grains to the ounce of water, with a little glycerin) be employed until the irritation subsides. After a few days of this treatment, ointments, or other forms of application, may, with advantage, be substituted for the lotion.

Hardy recommends frictions night and morning with an ointment of thirty to forty grains of flowers of sulphur and fifteen grains of camphor to the ounce of lard. Bazin prefers an ointment of fifteen to thirty grains of turpeth mineral to the ounce. Fox uses, after epilation, a two to five per cent solution of salicylic acid in alcohol or castor oil. Lailier

recommends the continuous applications of compresses saturated with sublimated glycerin.

According to my experience, an ointment of chrysarobin, ten per cent, and salicylic acid, five per cent, is one of the most efficient topical applications. I prefer to use these drugs, singly or in combination, in collodion or traumaticin, forming a fixed impermeable dressing which may be renewed whenever it begins to crack or lift up from the surface. This dressing possesses the advantages of maintaining the active agent in continuous contact, while excluding the air; a supply of oxygen being regarded as essential to the life of a vegetable parasite. Used in this way, general staining of the hair, the production of chrysophanic conjunctivitis from transference of particles of the drug to the eyes, and other attendant disadvantages are obviated. Pyrogallie acid, five per cent; iodine, five to ten per cent, and other active agents may be employed in these combinations. Coster's paste (iodine, 3 i., to colorless oil of tar, 3 iv.) and an ointment of the oleate of mercury, five to ten per cent, are also efficient as parasiticides.

Active treatment should be suspended from time to time in order to ascertain whether a cure has been effected. Should clinical or microscopic evidences of the disease be again manifest, a second or even third series of epilations, followed by parasiticide applications, should be employed until a complete cure is obtained.

As a general rule, it will be found that the readiness with which the disease responds to treatment is directly proportionate to its chronicity and the consequent deep diffusion of the spores.

In the treatment of tinea, as before intimated, there is a wide field for the selection of remedies. Experimentation has not only been active in testing their parasiticial action, but also in devising expedients for bringing them in direct contact with the microphyte. Ether has been recommended as a menstruum on account of its property of dissolving fatty matter; chloroform on account of its power of penetration; lanolin on account of the facility with which it is absorbed, etc. Harrison has recently recommended iodide of potassium in liquor potassæ for softening the hairs, and the subsequent application of a mercuric bichloride solution, on the theory that it readily penetrates to the roots of the hairs, and a chemical action takes place, resulting in the formation of the biniodide of mercury, which destroys the fungus. These, and many other methods which have little but their ingenuity to recommend them, have been referred to in previous numbers of this JOURNAL. The treatment outlined above will probably prove as efficient as any that may be adopted.

One caution should be observed in the selection of a parasiticide, which is, that it should never be of such strength as to cause destruction of the tissues themselves. The intense dermatitis determined by certain

irritants may produce a permanent alopecia, which favus rarely, and tinea tonsurans never occasions. Ladriet's treatment of tinea with croton-oil pencils, which has for its object the production of an artificial kerion by setting up a suppurative inflammation of the hair follicles, is on this account to be condemned. Cramoisy's treatment by pyroligneous acid, the use of glacial acetic acid, blistering the scalp, and other severe measures are likewise objectionable. It is well, also, to remember that the susceptibility of the scalp to irritants varies in different individuals, and the strength of the application in each case should be measured by the reaction produced.

In the treatment of tinea affecting the beard, the same general principles of treatment obtain. Epilation, with the use of an ointment of iodide of sulphur (thirty or forty grains to the ounce), I have found most serviceable. Good results may also be obtained from the use of an ointment of the oleate of copper or mercury (ten per cent). In eczema marginatum, the use of sulphurous acid diluted one-half, painting the affected surfaces with chrysarobin in traumaticin (ten per cent) or iodized collodion (tincture of iodine and collodion equal parts), as recommended by Piffard, will be found efficient. The use of the bichloride in tinct. benzoin (2 grs. to  $\frac{5}{8}$  i.), as recommended by Taylor, is also a convenient and efficient application.

The treatment of tinea versicolor is usually more promptly efficacious than that of other vegetable parasitic diseases of the skin. Energetic frictions with tincture of green soap, repeated for several days, are often alone sufficient. Painting with tincture of iodine, or the use of chrysarobin, pyrogallol, or salicylic acid in traumaticin or collodion, readily removes the superficial epidermis in which the microsporon has its seat.

60 W. 40TH ST.

## CLINICAL NOTES ON THE VALUE OF RESORCIN, ICHTHYOL, AND LANOLIN IN CUTANEOUS DISEASES.<sup>1</sup>

BY

HENRY W. STELWAGON, M.D., Philadelphia,

Physician to the Philadelphia Dispensary for Skin Diseases, Chief of the Skin Dispensary of the Hospital of the University of Pennsylvania, etc.

**R**ESORCIN: Employed in 25 cases of eczema, 5 cases of trichophytina, 3 cases of tinea versicolor, 6 cases of leg ulcer, 20 cases of seborrhœa and alopecia, 5 cases of psoriasis, 2 cases of sycosis, 1 case of lupus erythematosus, and 1 case of favus; total, 68 cases. In eczema,

<sup>1</sup> Read at Tenth Annual Meeting of American Dermatological Association.



the remedy at times acts satisfactorily; but in the greater number of cases it aggravates. It seems to act best in eczema rubrum, and when the disease is upon the lower extremities. It should not be prescribed in greater strength than a ten-per-cent ointment—in fact, rarely more than thirty grains to the ounce. If applied in greater proportion, there is but one result, and that is, marked aggravation of the disease. In erythematous eczema also, it occasionally has a good effect. While a few cases of eczema were permanently relieved by this remedy alone, such a result is exceptional. It is more in the power that resorcin appears to have in controlling the itching that its advantage is seen. In this respect, it seems with present limited experience to be an addition to the therapeutics of eczema.

Of the five cases of trichophytina, two were ringworm of the bearded region, and the remaining three of the scalp. Of tinea sycosis, both cases were of moderate degree: cure was effected in one case in three weeks; in the other, the result was good, but it required a longer period to secure it. In the three cases of ringworm of the scalp, it seems to be on a par with most other remedies usually employed; while under observation (five weeks), they improved slowly. In these five cases of trichophytina, extraction of the hairs, although advised, was inefficiently carried out. The strength of ointment used was ten to twenty per cent.

In tinea versicolor, either as a lotion or ointment, resorcin has a curative action, but it is inferior to the common remedies employed. Used side by side with hyposulphite of sodium, the latter is found to be much more rapid in its effect.

In painful leg ulcer, resorcin in some cases acts admirably. In five of the six cases recorded, pain was almost instantly allayed; and in one, a complete cure resulted. In four cases, improvement was noted, but healing only progressed to a certain point. In the sixth case, marked aggravation followed. It was employed in strength varying from eight to twelve and one-half per cent, the ointment kept constantly applied, renewing usually twice daily. In seborrhœa, and also in alopecia dependent upon this disease, good results may be, in some cases, obtained by employing an application similar to that recommended by Ihle, consisting of a drachm of resorcin, one to two drachms of castor oil, four or five minims of Peruvian balsam, and four ounces of alcohol. This should be applied every night, being well rubbed in, and the scalp shampooed every four or five days. While the result with this plan of treatment is not always positive, its action in a fair proportion of cases entitles it to favorable comment. In psoriasis, as also in sycosis, the drug seems practically valueless. In the single case of lupus erythematosus in which it was tried, there was no improvement. In one case of simple superficial epithelioma occurring on the nose it was used as a strong ointment,

forty per cent, and so far (two months after healing) the result has been good. In a second case in the same locality, and in a third case occurring about the ear, it was without effect. In a single case of favus of the scalp, in a boy of 15, resorcin was used faithfully for two months, apparently with little, if any, effect; the ointment used consisted of two drachms of resorcin and six drachms of lanolin.

Ichthyol: Employed in 8 cases of *acne rosacea*, 10 cases of *acne vulgaris*, 12 cases of *eczema*, 4 cases of *furunculus*, 3 cases of *psoriasis*, and 1 case each of *lupus erythematosus* and *favus*; total, 39. The cases of *acne rosacea* were of the ordinary type, redness being due more to simple stasis than to permanent enlargement or dilatation of the vessels. The strength of ointment used varied from five to thirty per cent. The stronger ointments proved too irritating in the majority of cases, and it was found that the strength generally suitable was ten per cent. In one of the cases, the result was good, marked improvement following within a few weeks after beginning treatment; in two cases, the result was fair; in one other, the improvement was slight; in the remaining four, no change for the better occurred, and, in fact, in two of these the disease was aggravated. In *acne vulgaris*, the degree of usefulness was about the same as in *acne rosacea*: two cases were practically relieved, three somewhat improved; in three cases, no change; and in the remaining two cases, the disease was made worse. The strength of ointment varied from five to fifty per cent; the strongest applied to lesions only. In the average case, where the application was made to the whole face, a ten-per-cent ointment was employed.

In *eczema*, ichthyol, as was to be expected, was found applicable only to the squamous form. In vesicular and erythematous *eczema*, as well as the other acute and subacute varieties, it is irritating. Even in squamous *eczema* it has no positive beneficial effect. It was employed in this form in the strength of one or two drachms to the ounce. In *furunculus*, ichthyol in the form of a stiff ointment applied as a plaster proved valuable in two of the four cases, the beginning furuncles aborting, and those that had partly and fully matured becoming less painful, and healing satisfactorily. The strength of plaster used was twenty per cent. In the third case, the application appeared to be beneficial. In the fourth case of this disease, the effect was negative. In the three cases of *psoriasis* in which this remedy was used, in thirty-per-cent ointment, the lesions were practically uninfluenced.

In the case of *lupus erythematosus*, ichthyol was prescribed in ointment form, ten and twenty per cent strength, with slight improvement, but there was no positive effect. In the single instance of *favus* of the scalp, the same case in which resorcin was tried, ichthyol was used as a twenty-five-per-cent ointment for a period of three months, and at the

end of that time it was difficult to say that the disease had been perceptibly improved.

**Lanolin:** This ointment base, consisting of about seven parts cholesterolin fat and three parts water, now well known, will probably win for itself general recognition. As with all new and costly remedies, it is not always easy to procure a thoroughly reliable preparation. Although lanolin (as introduced by Liebreich) should contain about thirty per cent of water, a sample accidentally came under my notice lately with which it was impossible to incorporate the slightest additional amount of water, showing that complete saturation had been practised, or, in short, the sample apparently was made up of equal parts of cholesterolin fat and water. In one instance also the specimen consisted of pure cholesterolin fat, although labelled lanolin, there being an entire absence of water.

Cholesterolin fat alone should, for obvious reasons, be the ointment basis (rather than the mixture with water), from which to prescribe; water or any other substance being added in the proportion circumstances might demand. This fat, as manufactured at present from sheep's wool, has the strong sheep odor, disagreeable in the extreme, but this, strange to say, is to a great extent lost when mixed with water, so that in lanolin the sheep's odor is not at first so noticeable, but when applied to the surface the heat of the body soon dissipates the water, and the disagreeable odor is developed. This odor is the main disadvantage of lanolin as an ointment base. Another disadvantage is its consistence, which may be obviated, however, by the addition of twenty to thirty per cent of an ordinary fat. Within the past month Liebreich, in a note in the *British Medical Journal*, calls attention to an improved lanolin—lanolinum purissimum—in which the cholesterolin ethers are entirely absent, and the consistence such that no addition of other fat is necessary.

It is now, I think, by various authorities proven beyond doubt that lanolin is more rapidly taken up by the skin than any other fat. This property is susceptible of clinical proof, and in this, therapeutically, is its great advantage. In acute inflammations where merely a protective influence is the object, this property is undesirable, and in such cases, if ointments are used, cold cream, vaseline, or a mixture of vaseline and lard is preferred. On the other hand, in cases of chronic eczema, psoriasis, and similar diseases, where there is thickening or infiltration, and a degree of penetration is desired, then lanolin is superior to the ordinary fats. In a few cases of an acute and subacute type the application of lanolin proved, for some reason, irritating.

In sycosis and the parasitic diseases, lanolin was also used as the ointment base, and although, theoretically, it should be vastly superior, my experience so far has failed to prove any marked advantage in these cases over simple lard.

NOTES OF A CASE OF EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA?), WITH BULLOUS LESIONS.<sup>1</sup>

BY

W. A. HARDAWAY, M.D.,

Professor of Dermatology in the Missouri Medical College; Consulting Dermatologist to the St. Louis City and Female Hospitals.

I HAD hoped to present the notes of a number of cases under the general title of "exfoliative dermatitis," *e. g.*, illustrations of classical pityriasis rubra, pemphigus foliaceus, together with intermediate forms of disease belonging to this family group, but circumstances have compelled me to surrender my design for the present, and to ask your attention to a very brief and somewhat imperfect account of the following unusual case:

On Feb. 21 of this year, I was asked to see a lady who was suffering from a very annoying and extensive disease of the skin.

The patient, who was confined to bed, was of about forty-five years of age, very stout, and somewhat nervous. I found that she had always been an exceptionally healthy person, and indeed, barring a slight facial neuralgia, had never been seriously sick at all. She had never suffered from a skin disease of any description before.

The present affection dates from on or about the 1st of February, and followed upon attendance on an evening entertainment, where she was much fatigued. Coming home late at night, she felt thoroughly chilled in the carriage, and went to bed feeling ill. The next day she noticed that there was a red patch at the pit of the stomach, which itched a little, and spread rapidly, the different red places that afterwards developed soon running together and leaving no healthy skin between. There was no great amount of scaling at first, but some degree of pruritus. She positively declares that there was no moisture.

When I first saw the patient, the disease had been in progress perhaps for twenty-one or twenty-two days. The chest, abdomen, arms, back, and thighs presented the usual appearances of pityriasis rubra. There was neither moisture, crusts, nor appreciable infiltration, but the skin was shining and of a marked violaceous hue. She complained at this time of great burning and tension of the integument; the sensation of itching had seemingly subsided. She was very nervous, and altogether wretched.

In the mornings, a handful of scales could be gathered from the sheets, but they were not so large as is usual, and were inclined to be

<sup>1</sup> Read at Tenth Annual Meeting of American Dermatological Association.



furfuraceous. Still the desquamation was a marked feature of the attack. The face was not involved, and on the legs below the knee there were at this time some uninvaded regions.

Three or four days after I had first seen the patient, and about twenty-four days from the beginning of her disease, there appeared on the thighs, abdomen, and buttocks, where the skin was highly inflamed, a number of tense bullæ, varying in size from a finger-nail to a silver twenty-five-cent piece.

This new manifestation was preceded by a distinct chill, just as I have observed in pemphigus foliaceus, and was followed by a moderate elevation of temperature. The blisters did not run into each other, but kept their individual characters until punctured by the patient, which she did on account of the pain and discomfort produced by them. Their contents were clear. I presume that there were never more than a dozen bullæ out at one time, but each crop was preceded by a chill. There was no regularity, so far as I could make out about this symptom, as to the time of day of its occurrence; but some time in the morning or some time in the afternoon the patient would observe that a crop of bullæ had supervened upon a chill. The bullæ were not grouped, but scattered irregularly over the surface.

I gave the patient freely of quinine, and at the end of a week the bullæ had ceased to appear, but, of course, I cannot say whether they would not have disappeared just as well without the quinine.

The floors of the bullæ differed little in appearance from the surrounding inflamed skin, being perhaps a little redder and somewhat more moist at first. When the roofs of the blisters were hanging in shreds on the reddened skin, there was a certain resemblance at these points to pemphigus foliaceus.

At this period in the case I was obliged to discontinue my visits, and what was the further history I am unable to state definitely, but I believe that the patient gradually improved.

My assistant, Dr. Eversole, saw Mrs. X. some time later, after the bullous stage had passed away, and he told me that the affection presented the usual features of pityriasis rubra. I wrote the patient recently for further notes of her case, but I have as yet received no reply, as she had left town for the summer.

So far as I know, the only other case bearing much resemblance to the one I have recorded above has been recently reported by Dr. P. A. Morrow (*JOURN. CUTAN. AND VEN. DIS.*, June, 1886), in which a well-marked case of pityriasis rubra presented numerous pin-head-sized vesico-pustules as a complication.<sup>1</sup> I shall refrain from making any es-

<sup>1</sup> Weyl (*Ziemssen's Handb. der Hautkrankh.*) says that in dermatitis exfoliativa acuta a few feeble vesicles may appear.

pecial comment on this case until I shall have an opportunity to publish the whole series, of which this forms a part.

However, so much may be said at least, that certain forms of disease, which have generally been regarded as running a dry course, may be complicated under certain circumstances by lesions containing fluid.

---

#### A CONTRIBUTION TO THE CLINICAL STUDY OF SCLERODERMA.<sup>1</sup>

BY

J. E. GRAHAM, M.D.

**S**CLERODERMA is a somewhat rare and obscure disease which, notwithstanding its well-marked clinical characters, still baffles all efforts made to ascertain its true pathology. The following histories of two cases are simply given as additional examples of the disease. They do not present many points different from those already described, yet every case has some peculiarities of its own which may, along with others, help to make up a true clinical picture of the disease.

The first case occurred in the practice of Dr. Smith, of Seaforth, Ontario, to whom I am indebted for the notes, given in his own words, in this paper. The history is as follows:

Mrs. R., age 47, came under my notice in August, 1882, while visiting relatives in Canada. Her home was in the northern part of Michigan. The family history was good, and the only severe illness she ever had was eight years previously, when she suffered from acute rheumatism.

About seven months previous to coming under my notice, she had a severe chill after a hard day's work, and a day or two later she observed that a small portion of the skin on the back of the neck felt hard, and this soon spread over the neck until turning the head from side to side became quite difficult. She felt as if something were tied tightly around the neck. During the next two weeks the disease gradually spread until nearly the whole integument of the body became indurated. When I first saw the patient, she told me that she felt as if the whole body was wrapt in thin, hard leather. She walked and moved her arms with considerable difficulty, and she evidently suffered no little inconvenience from the "tightening" of which she complained. The fingers and toes were slightly bent and deformed. The respirations were more or less interfered with, and the appearance of the mouth and eyes was most peculiar. The temperature was normal and the degree of sensibility was but slightly impaired. She had consulted several physicians, but she had

<sup>1</sup> Read at the 10th annual meeting of the American Dermatological Association.

never put herself under any thorough course of treatment. I prescribed for her Syr. Ferri Iodidi and Liq. Arsenicalis, the latter in five-minim doses after each meal. As a local stimulant, I recommended the use of electricity, and directed her to procure a battery and to persevere in its use daily.

I had some difficulty in getting her to consent to follow out the above treatment faithfully, owing to the fact that she had already become discouraged. She returned to her home in Michigan and informed me, six weeks after her return, that the skin was becoming somewhat softer to the touch, and that she could walk and use her arms with much more freedom. I advised the continued use of the remedies prescribed, and wrote to her to be particularly careful to use the battery as directed, rubbing the body and limbs carefully with the sponges, as I had shown her.

At the end of three months, I was glad to receive the report that she was almost entirely free from the disease. She has since enjoyed fair health, but has had no return of the scleroderma.

In this case, there was no œdema at any time. There was slight pigmentation at the back of the neck and over the upper lip. Dr. Smith did not inquire if rheumatism existed in the family, but is inclined to think that there is a hereditary tendency to that disease.

The second case, sent by Dr. Jenner, came under my observation last May, when the following notes were taken:

Mr. H. æt. 39; married; occupation, carriage-builder. Family history shows evidences of hereditary rheumatism. His father, who died aged 77, suffered for many years from rheumatism, which rendered him unable to walk without crutches. One brother had rheumatism for some years and died of Bright's disease. There is no other history of hereditary disease. The patient himself enjoyed good health previous to the commencement of present disease. He has never suffered from any serious disease or injury. He used tobacco up to ten months ago, when he gave up this habit. He has been a hard-working man, standing always at the bench.

About seven months ago, he first noticed stiffness of the limbs, as though he had caught cold. When at work, the stiffness would leave him, but would return at night when he remained quiet. At the same time, he had swelling of the legs. So far as could be ascertained, the swelling was due to œdema. This continued for six weeks, during which time he bandaged the legs. About the middle of December, *i. e.*, four weeks after the commencement of the œdema, he noticed a discoloration of the hips and groins, which he thinks came on quite suddenly. In about the middle of March, his brother noticed that the skin over the hips and thighs was hardened. It is probable that the induration began some

weeks previously, but was not noticed. This hardened condition spread quite rapidly, until the integument over the trunk and limbs became more or less affected. For the last two months, there has been no change in the extent or amount of the induration. He has lost weight. He has suffered much from constipation. The urine has not been increased in quantity, but at the commencement of the illness he had to pass water much more frequently than normal.

Present condition: Patient is tall and thin; weight at present one hundred and sixty-five pounds. He has a dark complexion and blue eyes. He cannot remove his coat without assistance, on account of stiffness of the arms. The skin of the chest is tightly drawn over the ribs, so that there is very little expansion of the chest, even on deep inspiration. The integument is not thickened in this region, and the tension is much greater anteriorly than posteriorly. It was found also that the skin was much tighter when the patient was standing than when sitting. There was no discoloration over the chest.

*Abdomen.*—Anteriorly, the skin is tense, somewhat thickened, and the lower part is discolored. Over the right and left inguinal regions the pigmentation is most marked, the integument being as dark as that of a mulatto. Cannot pinch up the skin over the front of the abdomen. Posteriorly, over the lumbar and sacral regions the skin is extremely tense, indurated, and very deeply pigmented, and presents a shining appearance. Over the gluteal region there is also tension and induration, but neither of these conditions is as marked as over the parts higher up.

*Thighs.*—Over the hip-joints the disease exists to its greatest extent. The parts are as hard as wood, and the integument is firmly attached to the parts beneath. The discoloration also exists here in its greatest intensity. Over the lower part of the thigh the disease exists in a uniform and milder form. The condition is intensified when he stands up. He is more inconvenienced by the stiffness in the popliteal region, as it affects his getting up and maintaining the erect posture.

*Legs.*—The discoloration is greater over the legs than over the thighs. Anteriorly, there are some white spots, showing complete absence of pigmentation. Here the skin presents more of a cicatricial appearance than over other parts of the body. The calves are atrophied, and the skin over them very tense. On the other side of the right leg the brown pigmentation is interrupted by white lines, which cross one another so as to give it the appearance of a checker board. Patient states that, where there is now absence of pigment, there was at one time deep pigmentation. The skin of the feet is also tense, and the discoloration gradually diminishes to that over the toes, where the condition is about normal. There is some stiffness of ankle-joints.



He sleeps well and suffers no pain whatever. Patellar tendon reflex absent. No ataxic symptom in either upper or lower extremities.

His heart and lungs are healthy. Appetite good. Pulse ninety. Temperature normal. Respiration twenty-three. The frequency of respiration and pulse is probably owing to the difficulty of expansion of the chest. He complains of a feeling of tightness after eating a full meal. His eyesight and hearing are good. He has never suffered from mental worry or shock.

He walks with some difficulty, but can go a long distance. His steps are short, and he experiences great difficulty in arising from a chair. The impediment in moving is due entirely to the condition of the skin. The face and neck are not affected. There is diminished sensibility over some of the sclerosed parts, while over others the sensation is normal.

This patient was put on potass. iodid., syr. ferri iodid., and cod-liver oil. The constant current was applied centrally and locally. Friction of the parts with olive oil was also recommended.

The patient remained under my care for about three weeks, and then went home. Dr. Jenner has written me lately that the condition is somewhat improved.

He has for the last few weeks taken salicylate of soda, without any good result so far.

It is not the intention of the writer to more than merely discuss some points which appeared to him of interest in connection with this obscure affection. In the first place, as to the frequency of the disease, Dr. Van Harlingen, in his exhaustive article published in 1873, gives twenty-eight cases which he had collected from various sources, twenty of whom were females and eight males. From a brief survey of the literature from 1873 to the present, I found about thirty cases. Dr. Crocker, who includes morphea with scleroderma, places the number of recorded cases at 120.

Like other rare affections recently described, it will be found that cases are more numerous than at first supposed. It is probable that the disease occurs more often in temperate climates, where there are frequent and sudden changes of temperature. In the writer's limited field of observation, three cases of scleroderma and one of morphea have occurred during the past ten years. It will be found that, of the recorded cases, only two or three are reported from warm climates, and that the great majority have occurred in the temperate region of Europe and America.

It is quite improbable that such a general condition as scleroderma can be a purely local disease. There are doubtless pathological conditions existing in the deeper organs which have so far escaped observation. Two classes of diseases suggest themselves as likely to be more or less connected with this condition, viz., the tropho-neuroses, and secondly, the

various forms of rheumatism. It has been the generally accepted opinion that scleroderma is a tropho-neurosis, and that the true cause exists in the trophic nerve centres. One great difference, however, exists between some trophic diseases, such as prog. musc. atrophy, pseudo-hypertroph. musc. paralysis, and that under consideration, viz., that in the former the lesion, in most cases, is either permanent or progressive in character, whereas in scleroderma, in many cases, recovery takes place sooner or later.

In my opinion, the disease is more nearly allied to the rheumatic affections. By this I do not mean to deny that there is also a close relationship with the tropho-neuroses, for I regard many rheumatic joint affections as of a neurotic origin. It has been clearly shown that the arthropathies which Charcot has described in connection with locomotor ataxia are of nervous origin, and Dr. Ord, in his address on medicine before the British Medical Association, in 1884, also demonstrated the intimate relationship which exists between certain rheumatic affections, such as rheumatoid arthritis and trophic nerve lesions.

Now, as to the connection of the disease with rheumatism, Dr. Duhring states that "rheumatism, especially of the joints, has been noted to precede the attack in many cases."

In the clinical lectures delivered by Dr. Crocker last year, the following opinion is given:

"What is, then, the relation of acute rheumatism to scleroderma? Is it etiological? I scarcely think so. While there are on the one hand only a moderate proportion of scleroderma patients in whom the two diseases are associated, there are many scleroderma cases in which there has been no antecedent or associated rheumatic fever, while scleroderma would not be so rare if so common a disease as rheumatic fever was of direct etiological importance. I regard them, and also ordinary articular rheumatism which frequently accompanies scleroderma, as being due to a common cause, viz., exposure to cold, which is one of the most frequent and important causes of scleroderma."

It must be remembered that there are a great variety of affections classified under the head of rheumatism and rheumatoid arthritis.

Any one who studies the subject of rheumatism, particularly that of a hereditary character, will be surprised to learn of the infinite variety of its manifestations. It may occur in some as an arthritic affection, in others the muscles and tendons are attacked, while in others again the principal difficulty is an abnormal state of the digestive and assimilative functions. It has recently been shown that, in this way, an intimate relationship exists between rheumatism and some forms of diabetes, and that anti-rheumatic remedies, such as salicylate of soda, will act favorably on these cases of diabetes.

Taking this view, it is not so difficult to suppose that scleroderma may be one of these varied manifestations. It is not necessary, therefore, to show that a majority of scleroderma patients have also had rheumatism, but it would be of interest to know in how many cases a predisposition to rheumatism, or what may be called a rheumatic diathesis, existed.

In studying the changes which take place in joints in chronic rheumatic affection, we find that they are often very similar to those which take place in the skin in scleroderma.

Thus you have first an increase of connective tissue which, in many cases, is followed by atrophy in the same way that we have hypertrophy of connective tissue in scleroderma followed by atrophy. In the chronic nature of the process, these two conditions resemble one another.

Morphœa, too, in some instances at least, seems closely allied to rheumatism, as is shown in the case related by Dr. Dyce Duckworth.

Again, in quite a number of cases of scleroderma, pericarditis is met with—a condition so often met with in rheumatism.

The frequency of rheumatism, and the rarity of scleroderma, is not an argument against the relationship of the two diseases. The rheumatic form of diabetes is also a comparatively rare disease, and still the relationship has been clearly shown.

On going over the whole subject, I think there is sufficient ground for treating cases of scleroderma with anti-rheumatic remedies. We find that those means, such as friction with oil, Turkish baths, potass. iodid., have been found useful. Salicylate of soda has been used in two or three cases, but I do not know if salicin and other alkaline preparations have been tried in this disease.

Now, as to the much disputed point of the relationship of this disease with morphœa, it is probable that etiologically they are closely connected, and certainly cases have been described in which the two conditions are so closely combined that it is impossible to draw a dividing line between them. It may, however, be of advantage to consider them as two separate diseases until our knowledge of the two affections is more extensive and more accurate.

With regard to the chronicity of the scleroderma, I am of opinion that Dr. Duhring is correct in considering that we have an acute and chronic form of the disease. The first case given in this paper would belong to the acute, and the second to the chronic variety.

So far as I could learn, the acute is the rarer form. Only four or five cases have been published: one by Crocker, one by Piffard, two spoken of by Dr. Duhring, and two reported by myself. In the acute form, there is, I think, less pigmentation.

The two cases which I have known of, both were in women, and in both there was little or no pigmentation. There is also less atrophy.

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

165TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. DANIEL LEWIS presented a

#### CASE OF EPITHELIOMA OF THE FACE,

with the following remarks.

The patient was a man 53 years old. The disease began seventeen years ago, was first considered an eczema, was treated with benzoated zinc ointment, and arsenic internally, but instead of improving grew steadily worse. Then his physician, a very reliable practitioner of Sacramento, Cal., from whose letter this history is obtained, concluded the ulcer might be of a specific character, and treated him accordingly, but to no purpose. He then referred him to a dermatologist of San Francisco, who pronounced it a case of rupia, but after fifteen months' treatment totally failed to benefit the patient. The progress of the disease has been constant. Another physician endeavored to cure it by a thorough application of Vienna paste. Professional cancer curers have also had him in charge of late years. He reached my office a few days since with a dressing of "Cuticura Soap."

The disease began first as a slightly elevated patch about the centre of the right cheek, upon which a thin crust would form, and in a few weeks be detached by shaving and then reproduced—the usual history of flat epithelioma of the face. As far as I can learn, all ulceration has spread from this single point.

At present it involves a nearly quadrangular space extending from above the right ear to near the outer angle of the eye, downward to the inferior maxilla, backward to the inferior mastoid region. Most of the external ear has been destroyed, the surface of the ulcer being twenty-five square inches. In some portions, the disease does not extend much beyond the depth of the true skin; in others (as in the portion below the malar bone), it is a question whether it has not actually invaded the mouth. The posterior and inferior borders are indurated, elevated, and everted for some distance. The surface is not secreting copiously, nor are the secretions especially offensive. There are no enlarged cervical glands. There is no family history of cancer. He had a venereal sore thirty years ago, and a suppurating bubo. I cannot satisfy myself that he ever had syphilis, in fact believe he had not. His general health is impaired, chiefly as a result of peritonitis, three years ago, and considerable effusion, for which he was tapped several times. He now has a much enlarged spleen. I should like to have my diagnoses of epithelioma, *ab initio*, reviewed, and receive suggestions from the members of this Society in regard to treatment.

If it is deemed advisable to undertake *any* treatment, the plan I have to propose is this: to make an incision entirely around this ulcer and with the knife, secure as broad a border as possible which is healthy, and then treat the balance



of the surface by the Paquelin cautery. Unless some intercurrent trouble, disconnected with this disease, steps in to hinder this proceeding, I believe recovery possible.

In the discussion which followed, DR. JACKSON agreed with the diagnosis, but as regarded prognosis and treatment he differed from Dr. Lewis, believing that the operation proposed did not offer any chances of a permanent good result.

DR. SHERWELL said he would fear to operate, and considered euthanasia under suitable doses of opium the most desirable thing under the circumstances. The case was interesting to him as bearing out a previously expressed opinion, that many of these epitheliomata have their starting point in a mole upon the face, which has in some way become irritated. He had learned from the patient that he had cut off the top of a mole while shaving, and this appeared to be the point from which the disease took its origin.

DR. FOX said he should endeavor to prevent the further spread of the disease by occasional operation, and a radical operation might be attempted. He would scrape and cauterize the base which would improve the condition, even if it had no decided effect on the prognosis.

DR. BRONSON advised curetting a zone near the periphery, having the actual cautery at hand in case of hemorrhage from any large vessels. He thought that at many points ground might be saved.

DR. BULKLEY had seen two similar cases. In one, an attempt had been made to remove the disease by a radical operation, but a recurrence of the cancer soon resulted in death. In the second case, no radical operation was attempted. He would treat such a surface as here presented, with a corrosive sublimate solution 1:5,000, applying iodoform at times in combination with tannin and powdered starch. After a thorough excision of a portion of the disease, at the margin, he would like to see the bodily transplantation of a large piece of skin from the patient's abdomen. He had witnessed a perfect result from a large transplantation for ectropion resulting from syphilitic scarring.

DR. TAYLOR agreed with Dr. Bulkley as to the inadvisability of operation.

DR. SHERWELL had seen inflammatory reaction follow the use of iodoform, at the same time that a bichloride solution is being used, and for his part would not use the two drugs at the same time. Dr. Bulkley and Dr. Piffard had used iodoform after bichloride solutions many times, and had never seen any ulterior results.

In closing the discussion, DR. LEWIS said that the superficial nature of the ulcer, and the fact that the disease had progressed so slowly, made him believe that the procedure he proposed was justifiable. He did not believe it proper to leave such cases without treatment, not only on account of the bad moral effect of refusing to operate, but also because much benefit might result. He had thought of making the incision in the healthy skin about the ulcer, to insure better granulations than would start from a scraped surface. Dr. Piffard did not admit this proposition, believing that scars after curetting are usually good, the granulations prompt, and not so prone to form hypergranulation as after incision.

DR. BULKLEY presented

#### A CASE OF LICHEN PLANUS

of somewhat unusual form, of which the following is the history:

Mary Doyle, unmarried, aged 29, seamstress, presented herself at my clinic at the New York Hospital October 31, 1885, for the treatment of an eruption which presented and still presents some peculiar features.

The first lesions appeared upon the legs four years previous to her visit; and very shortly after, upon the forearms. Upon these places they have remained to the present time, in spite of considerable treatment and a pretty faithful attendance at the hospital for ten months. The patch at the nape of the neck came somewhat later. From the beginning of the eruption, itching has been a most marked feature, causing at times very great distress, as is evidenced also by the very extensive and in places deep marks of scratching.

When first seen, the eruption presented very much the condition seen at present, although during the period she has been under observation the lesions have changed their condition, many have disappeared, and new ones have formed. Some of these have at times exhibited very clearly the characteristic and typical flat summits, with somewhat of a depression, have been of a violaceous color, and have either vanished or developed into the larger brownish and purple lesions now exhibited.

At present the eruption is confined to the extensor surface of the lower legs and forearms, and covers a patch about an inch and a half in diameter, of irregular shape at the lower border of the scalp, in the median line behind. No other parts have ever been invaded. On the legs, the eruption consists of brownish and purplish lesions, varying in size from one-quarter to three-quarters of an inch in diameter, of irregular shape, scattered among brownish stains of former patches, and torn remains of others. Some of them are very perceptibly elevated, and rough and almost horny on the surface. On the forearms, the lesions are fewer and smaller, with occasional papules typical of the disease, and scratched papules and stains. On the nucha, the patch is made up of more closely set lesions, forming a quite even patch, much resembling the ordinary eczema seen in this location.

The treatment has been varied, but never with any very marked and permanent benefit, although improvement for a while has followed a variety of measures. Arsenic has never been well tolerated and has not proved of service. Locally, the liquor picis alkalinus has given the most relief.

The interesting features of the case are the peculiar localization of the eruption, the brown, hard character of the lesions on the lower extremities, and its rebelliousness to treatment.

DR. BRONSON regarded the case as one of the hypertrophic forms of lichen planus, and suggested as local treatment strong application of carbolic acid.

DR. BRONSON presented

#### A CASE OF DERMATITIS HERPETIFORMIS.

The patient was a man 32 years of age, of fairly robust appearance, and with a history of good average health. Seven years before, he had had an initial lesion followed by adenopathies and some alopecia during the first year, but had had no symptoms since. Present eruption began about five years ago in the spring, and had continued almost without intermission until now. When first noticed, its efflorescences were papular and seemed to affect the sites of the hair-follicles, always occurred in groups, and were attended with itching. Latterly they have been vesicular. At present the groups are scattered over the greater part of the body and extremities, and vary in size from one and one-half inch to two or three inches in diameter. They are composed of small papules (often eroded) and vesicles, some miliary and some larger in size. Occasionally, bullæ are produced as large as the little finger nail. The vesicles are usually tense and clear. In certain places, as on the thighs and buttocks, the groups are distinctly annular. In other situations, there will be merely a cluster of from three to five efflorescences. The majority of the lesions consist of a papule surmounted either by a bloody crust or a vesicle so fine as to be visible only when the part is pinched up between the thumb and finger. Many (if not all) of the lesions appear to proceed from hair-follicles. They are distributed alike over the trunk and extremities; less frequently on the face, and never on hands or feet. Has heretofore obtained marked relief from Fowler's solution of arsenic.

In discussing Dr. Bronson's case, DR. SHERWELL spoke of two cases of this disease which he had observed, in which he was led to examine the urine for sugar and found it present in both cases. He asked if this patient's urine had been examined. It was stated that it had been and was found free from sugar.

DR. BULKLEY, in protesting against the name *dermatitis herpetiformis* being given to a great variety of affections presenting polymorphous lesions, nevertheless looked upon this case as one which could properly be so designated, on account of the herpetic element being marked.

He reported, in regard to the case of *dermatitis herpetiformis* presented at the January meeting, that the young man had fully recovered under full doses of arsenic in the form of arseniate of soda given up to the point of toleration, taking as much as ten or fifteen drops or more of the solution three times daily. He had found it better, in some cases, to give the drug on an empty stomach, either alone or in Vichy water.

In closing the discussion, DR. BRONSON said that, if the name *dermatitis herpetiformis* was ever justified, it surely was in this case, because of the tendency to herpetic groupings and forms manifested, and on account of the vesicular character of the early lesion. His patient had found great relief from the use of arsenic, especially in controlling the itching and burning, but was forced to abandon its use on account of its constitutional effect. He had been able to use Dr. Keyes' prescription of arsenic, *nux vomica*, and pepsin without any bad effect upon the stomach.

DR. TAYLOR presented a case of

#### URTICARIAL ERUPTION DUE TO IODIDE OF POTASSIUM,

with the following history, read by his house surgeon, Dr. J. A. Bosch.

The patient, Mary Johnson, aged 26, single, German, domestic. Ten years ago, she had vaginitis; eight to nine years ago, she had buboes in both groins. Three months after this, she contracted a sore on her privates, which was followed by an eruption, sore throat, and falling of the hair. Three years afterward, she states, ulcers broke out on her legs. She was treated with iodide of potassium, and soon developed an iodide eruption, similar in character, she thinks, to the present. One year ago, she entered Charity Hospital with an *ecthymatous syphilide*. She was put on treatment, and left the hospital much improved. She re-entered the hospital September 23d, complaining of her old symptoms, and was put on gr. xv. doses of the iodide, t. i. d. After the fourth or fifth dose, she developed an eruption of the urticaria type, with well-marked symptoms of iodism. The iodide was stopped, and the eruption has changed somewhat in character.

The eruption appeared within twenty-four hours after the first fifteen-grain dose of the drug, and showed all of the characteristics of an urticaria, occupying and being confined to the backs of the hands and wrists, and the face and neck. Many of the wheals were surmounted on the second day of the eruption by a pellucid vesicle.

Dr. Taylor believes that urticarial eruptions, due to the ingestion of the iodide, are not at all common, and thinks this case of especial interest at this time, when so much attention is being paid to iodide eruptions, from its rarity, the region occupied, and the fact that this is the second time he has observed the patient to be thus affected by the drug.

In the discussion which followed, DR. MORROW regretted that the urticarial wheals described by Dr. Taylor had in a great measure disappeared, leaving appearances which could with difficulty be differentiated from the syphilitic lesions present. He would not expect a syphilitic eruption to terminate so abruptly upon the backs of the wrists as in the case presented. Although he personally had never seen a case of urticarial eruption due to iodide of potash, many cases of this eruptive form had been recorded, and he had no doubt Dr. Taylor was correct in



the present diagnosis. In this eruption the larger papules are surrounded by an areola, and differ from ordinary urticarial papules by their higher coloration.

Dr. FOX related the case of a woman with syphilis he had treated some time ago, who had repeated outbreaks of vesico-pustules. He had suspected the iodide she was taking as being the cause of the eruption, and suspended its use, but the eruption appeared when she was not taking it, and did not appear at times when she resumed it again. By tests of this nature he was enabled to conclude that the iodide was not at fault.

Dr. LEWIS said he had never seen urticaria from the use of iodide of potassium, but as he was not in the habit of giving large doses, excepting in cases of syphilis of the brain, it might be on that account that he had not observed it.

Dr. BRONSON never saw an urticaria due to iodide, and was inclined to think that the eruption was not due to an idiosyncrasy for iodide of potassium, as much as to a general drug idiosyncrasy. Urticaria may be produced by any substance taken into the stomach which will produce reflex irritation.

Dr. MORROW asked if Dr. Bronson meant by a general drug idiosyncrasy that the intolerance of iodide of potassium exhibited by this patient would also be manifest against quinine, arsenic, and other drugs.

Dr. BRONSON said he meant that, under certain conditions, a great variety of things will cause an urticaria, among them certain drugs, and that he knew of no reason why iodide of potassium might not also do so.

Dr. BULKLEY called attention to the appearance on the patient's hand, where in fading away the urticarial wheal had left a halo surrounding a central papule. This solid element being left behind was a feature of urticaria which he had previously noticed.

In closing the discussion, Dr. TAYLOR said the connection between the eruption and the ingestion of the drug was undoubted, since all other factors had been eliminated. This fading of the urticarial appearance of the eruption, leaving papules behind, as spoken of by Dr. Bulkley, presents a condition which would at the present time be called a papular erythema following iodide of potassium.

Dr. TAYLOR then presented a boy having upon the penis an anomalous lesion which had been described by Dr. Morrow under the name of

"DIPHThERIC CHANCER."

The patient, aged 16, entered Charity Hospital, September 10th, 1886. His history was rather unsatisfactory. About twelve weeks prior to admission, he noticed a small pimple situated on the glans penis, which he states appeared from two to three weeks after intercourse. He was careless about his toilet and allowed the subpreputial secretions to accumulate under the prepuce. A few days later, the pimple increased to about the size of a quarter dollar, extending on to the balano-preputial fold, and was covered by a glistening grayish-white membrane, resembling a diphtheritic exudation.

This membrane was intimately adherent, slightly elevated, and had a peculiar leathery consistence. The edges were somewhat raised and surrounded by a well-marked line of demarcation between its border and the tissues around it. The membrane was of a uniform thickness, and not surrounded by an area of inflammation. It was not painful on manipulation, appeared sluggish, and had a smooth, semi-cartilaginous, greasy feel. On examination of the tonsils, a similar condition was observed. Between his nates and surrounding the anus were about a dozen condylomata, extending anteriorly to the margin of the scrotum. These were irregular in outline, fairly well developed, and in some places had coalesced and presented a cauliflower appearance.

The glands in the groin, the cervical and epitrochlear glands were all enlarged.

He states that he noticed no roseola, nor alopecia; but the former condition may have existed and escaped his observation, owing to his careless habits. He



lived in the poorer quarters of the city with his family, all occupying but two rooms: washing themselves in the same basin and using the same towels.

When we come to the family history, we find that the boy's mother has been suffering from a sore situated on the corner of the mouth. This was indurated, and had no tendency to ulcerate. Her body was covered with a papular eruption which had been preceded by a roseola. She had in addition general glandular enlargement.

The boy's sister, aged 12, with whom he had been in the habit of sleeping, presented at lower vaginal commissure a small sore, bearing the same characteristics as the mother's. She had some oedema of the face, a slight conjunctivitis, and a circumscribed blush around the eyes. The inguinal and cervical glands were enlarged. A nephew of the boy, 9 months old, who slept in the same room, had a sore on either side of anus, about size of a half-dollar, which extended to nates. It was excavated, had a slough in centre, the borders were firm and hard, and it was attended with an ichorous discharge. There was also a sore on side of scrotum, and another on inner side of thigh, both about as large as a five-cent piece. They were painful to the touch. The glands in cervical and inguinal regions were markedly enlarged.

The throat was congested, and the child had emaciated rapidly since the appearance of these sores.

There was still a brother, aged 5 years, who had a suspicious-looking fissure on the corner of the mouth; it was of a grayish color, indurated, and not attended by any discharge. This boy had no constitutional symptoms, but the lymphatics were all enlarged. A married sister (mother of the baby), who slept in the same room with her husband and child, had had syphilis, but her symptoms disappeared under treatment.

DR. MORROW said this was a very rare form of initial lesion. He had seen a case with Dr. Bronsou, a number of years ago, of which this was a good counterpart, except that the lesion in this case occupied a smaller surface, and the more characteristic features were less developed.

The peculiar grayish-white appearance of the patch was here not so pronounced, and the layer not so thick. The location of the lesion, the unbroken character of the layer, its raised, well-defined border, the existence of condylomata about the anus and scrotum, and the almost complete absence of other specific symptoms made the two cases strikingly similar.

DR. BRONSON agreed with Dr. Morrow that this was a counterpart of his case in the period of decline, when it had lost its glistening appearance, and taken on a sodden look. He regarded the circumstance of the boy's elongated prepuce as an etiological feature; the leathery prepuce preventing abrasion or erosion, the epidermis remains intact and the whole process goes on underneath.

DR. TAYLOR had seen Dr. Bronson's case, and several others, and had written a paper on the subject for one of the early numbers of the *Archives of Dermatology*. He described the sensation the patch gave to the finger as a leathery feel, or like wet chamois skin between the fingers. The reason this patch of gray tissue had lost its characteristic shiny appearance was because it had been energetically treated, as had also the condylomata which had been much more luxuriant and so high that they would pass for simple warts or vegetations, or acuminate condylomata. They had been treated locally with calomel, salicylic acid, and Labarraque's solution.

DR. BULKLEY related a case he had recently seen, in which an

#### EPITHELIOMA

had formed upon the left side of the lower lip of a man who had had a similar growth removed from the right side six years before. The scar from the previous operation was perfect, and the new lesion entirely separate from it.

DR. PIFFARD asked if it was not the patient upon whom he had operated six years ago. Dr. Bulkley said it was. Dr. Piffard had also recently seen the case, and agreed with Dr. Bulkley that there was sound, healthy tissue between the scar of the right side and the recent epithelioma of the left. The patient had told him that he had been smoking on the well side after the original operation. Previous to the first cancer, he had smoked on the right side. Dr. Piffard believed that operation was the only advisable treatment.

DR. SHERWOOD reported a case of

#### PITYRIASIS RUBRA

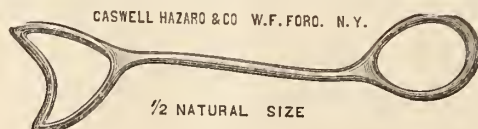
in a lady of about fifty years of age, who had been well until a little over a year ago, when the disease first appeared. He treated her, as was his custom, with inunctions of or rather soakings in linseed oil, and she recovered, and remained well for a year, until five days ago, when she again came under his care, and is being treated as before.

DR. BULKLEY reported that his two cases of pityriasis rubra, which had been unsuccessfully treated with the oil externally and internally, remained in about the same pitiable condition as at last reported. No treatment tried had done them any good. The woman of forty had been in the hospital for two years, and the ulcerations of the hands and feet were extremely painful.

DR. TAYLOR presented for inspection

#### AN ORAL SPECULUM,

being a modification of the very useful instrument of Dr. Piffard. The following cut gives an accurate idea of the speculum, which is well adapted to examinations



of the mouth and lips. The instrument shown was made of aluminum bronze, which seems especially adapted to such use by reason of its hardness, the durability of its lustre, and its resistance to acids and chemicals in general.

## Correspondence.

### MOLLUSCUM CONTAGIOSUM.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

SIR:—In your issue of August appeared an article from the pen of my colleague, Dr. Charles W. Allen, upon the subject of molluscum contagiosum.

My object in communicating with you at present is not to discuss the *pro* or *con.* of the contagiousness of this affection, but merely to describe two cases of it which came under my notice, and permit them to speak for themselves.

A year ago, I was consulted for an eruption which had appeared upon the left side of a boy's face. He was five years old. This eruption presented in the form of small tumors, globular, of a glistening white aspect, surmounted by a small black spot, each tumor about the size of a pea. They were located on the lateral

surface of the nose, the lower eyelid, and the cheek, and were four in number. These growths were treated by piercing them with the nitrate-silver crayon, and disappeared. Two weeks later, the patient reappeared with several more new ones. At the same *séance*, his sister, ten years old, was similarly treated for two little tumors similar to those upon the brother. Both of these cases showed evidences of great care as to bodily cleanliness, were well nourished, and healthy.

ETIENNE C. VIDAL, M.D.

NEW YORK, September 1, 1886.

### TREATMENT OF RHUS POISONING.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

SIR:—I presume you may be acquainted with the fact that the green vegetable, *Atropa belladonna* (night shade), bruised and mixed with fresh cream, cures the rhus poison by being applied externally over the eruption, in from three to seven days, without other medication. I have seen the whole face and head enveloped in such a poultice with no bad effect, and perfect cure result in five days. The application is freshly made daily until cure results. Respectfully,

T. J. REID, M.D.

CHICAGO, ILL.

### THE USE OF ARSENIC IN SKIN DISEASES.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

SIR:—Having read Dr. Fox's article on arsenic in skin diseases in the June number of the CUTANEOUS AND VENEREAL JOURNAL, and noted your article on Arsenical Eruptions, and the request for professional opinions in regard to the use of arsenic in skin diseases, in the July number of the same journal, I have watched for, and read with much interest, the several articles that have appeared in answer to the request, but have been disappointed that more have not responded, and that so little credit has been given this drug that, in my opinion and the opinion of many well skilled in the treatment of skin diseases, is of so much value. I have waited thus long, hoping that others would give their experience and call attention to some points that I think of vast importance.

As this has not been done, I shall venture a few remarks in reference to this remedy.

In the first place, let me make a criticism that many of my brethren will agree with me in. Our medical colleges of to-day are defective in this one thing, they teach the treatment of disease such as may be practised in the city, but which is not applicable in the country. The same may be said of our journals; the articles are almost every one of them written by men in the cities, and under most circumstances the treatment recommended cannot be carried out in the country or the small towns, consequently they are of very little use to the country practitioner. For this the writers and teachers are not to blame, but the fault lies with the country doctor, in that he rarely reports a case or gives his experience in the use of the different remedies.

As I have said of the treatment, so I say of the symptoms. We seldom find in practice just such symptoms in a given disease as is described as characteristic of the disease. The late lamented L. P. Yandell, Jr., used to say "treat the symptoms," and it is to the treatment of symptoms I wish to call attention.

All of the articles published in your journal in reference to this remedy have

been written in the East, except the one by Prof. Hardaway, which comes nearer to the point I wish to call attention to than any other.

It is known that, in some regions in this country, malaria is much more virulent than in others. In the maps published in the census of 1880, these regions are shown, and by referring to them and the authors of these articles, it will be seen that but one article comes from a man living in any of these regions; and as this poison yields a great influence on skin diseases, as well as diseases in general, and as we have this poison to contend with here, it is to the treatment of skin diseases in these regions I will call attention.

My firm belief is that, under these circumstances, arsenic is "nulli secundus," for the following reasons: In these regions skin diseases are mostly of malarial origin. Bartholow tells us what all who have tried it will agree to, that arsenic exercises almost a remarkable influence on neuralgia, jaundice, dysentery, diarrhoea, and fevers of malarial origin; then why not on skin diseases?

I assent that it does, and that it has this influence to a greater or less extent in parasitic as well as non-parasitic diseases. When used internally, it is true, it does not destroy the parasite, but the parasite has destroyed the tissues which are affected, and while the parasite may be destroyed by external applications, the tissues are left in such a diseased condition that their destruction will continue unless checked by other influences than merely the parasiticide. Arsenic checks retrograde, and promotes constructive metamorphosis, and in this way has a beneficial influence even in parasitic diseases.

In intermittent fever with recurring rigors, it is rarely possible to cure the disease without the use of arsenic. Quinine may interrupt the prodromes, but it remains for arsenic to eradicate the poison from the system. If it does this in diseases with internal symptoms, why will it not do the same in diseases with external local manifestations?

I have reason to laud this drug because of a personal experience with it.

Several years ago, I was attacked in August with an eczema which for six months resisted all the remedies of the materia medica, and all the local as well as the internal remedies recommended by those of experience with this disease, until in the following December or January I was put upon increasing doses of the liq. chloride of arsenic; under this treatment I rapidly improved and was soon well, and have never had a return of the disease. The trouble was of malarial origin, as I knew by the way it was contracted.

While arsenic was not used entirely alone, it was the principal drug, only small doses of the citrate of iron and quinine being given in connection with it.

In my own practice in the last few months, a number of cases of eczema have presented themselves, and have invariably been put upon arsenic in connection with a tonic, and always with the same result.

A short time since, a case of pemphigus came under my care, which was reported to recur every summer; it was at once put upon arsenic, and in less than a week was so much improved as to be considered almost well, since then has not been seen, but judge it is well or the patient would have returned.

These cases prove to me the good effect of this drug in these conditions, and while it gives me such general satisfaction shall continue to use it.

Prof. Keyes says that arsenic is a cutaneous stimulant, and as such should not be used in the acute inflammatory stage, but in the later chronic stage. I rarely wait for any inflammation to subside, especially if I can get a history of malaria, but put the patient immediately on the remedy I consider best to remove the cause, and in this way do away with the inflammation. Eczema is the skin erup-



tion most frequently met with here, but suppose I might say we never meet with what might be strictly called the "weeping eczema," therefore, while under some circumstances it might be well to postpone the use of arsenic until the subsidence of the more acute symptoms, we rarely find it necessary to do so.

I use Fowler's solution in gtt. v. doses, or the liq. chloride of arsenic in gtt. iij. doses and gradually increase if necessary, and I have never yet had it to cause trouble with the digestive organs when used under the above-mentioned conditions. While arsenic has the effect mentioned, if applied externally, even in persons considerably under the influence of malarial poison, I have reason to believe it may produce an eruption such as is described in the July number of your journal.

I should like to see some more opinions in reference to this remedy, especially from those using it in the above-mentioned districts. S. C. BALDWIN, M.D.

PRINCETON, KY., September 24, 1886.

## Selections.

### NON-VIRULENT ULCERATIONS OF THE GENITALS.

CLINIC OF DR. MAURIAC, PARIS.

NEARLY all the ulcerations which are found upon the genitals are of a virulent nature, that is to say, they are the result of the introduction of a virus, the product of a contagion, and are of themselves capable of producing by contact a lesion of the same appearance. At times, however, we may observe upon the genitals, rarely it is true, ulcerations which have no such origin, and are of an entirely different nature.

The *acne-form furuncle of the glans* is a lesion having certain features of the boil, but a much less rapid course, causing much less local reaction. It appears to begin in one of the follicles of the glans, and is characterized at first by a little hard tumor, which soon ulcerates and bears now a close analogy to the hard chancre.

In its next period, the tumor becomes hollowed out by a cavity of greater or less depth, resulting from the discharge of a quantity of sanguineous pus. Now the lesion closely resembles certain ulcerating chancres, or a gummy tumor. Finally, in its last period, cicatrization takes place with exceeding slowness, very unlike the rapid healing of syphilitic gummata. This acne-like furuncle presents then, as has been seen, great difficulties of diagnosis at times. The evolution of the lesion, the integrity of the inguinal glands, etc., will enable you to distinguish it from the chancre which it most closely resembles.

There is an affection which is generally considered a simple chancre of the gangrenous variety. It is called the *gangrenous affection or anthracoïde of the glans*. Contact plays no part in its development. It is usually found in the groove of the glans as a tumor which rapidly increases in size, and by reason of a very acute inflammatory condition, and perhaps also of some particular condition of structure of the organ, becomes very quickly a mass of gangrene, and what is remarkable, the gangrenous mass is not all proportionate to the size of the erosion

when first seen ; the gangrene extends deeply, and remains for a long time adherent to the adjacent tissues.

It is different with simple chancres which become gangrenous ; here the evolution is much less rapid, and the chancre goes through various changes before sphacelating.

The *anthracoidé* of the glans is accompanied usually with intense pain, much greater than that of gangrenous chancre, and similar to the pain of anthrax, ceasing only when the sphacelus has been formed. During the evolution of the disease, although there be often a marked effect on the general health, the inguinal ganglia remain intact and free from pain—a very important point to remember, and one which establishes a sensible difference between this and the gangrenous chancre. In the cases which Mauriac has observed, no condition has been noted, either in the local condition or in the general health, which can explain the development of this affection.

Dr. Mauriac has also observed abscesses of the prepuce with suppuration of the glands of the groin, quite analogous in aspect with those which complicate certain simple chancres, but differing plainly, not only in the conditions under which they appear, but also in the fact that the pus they contain is not auto-inoculable. We may also observe non-virulent abscesses with a chronic course, which are neither associated with a gonorrhœa nor simple or syphilitic chancre. We must also bear in mind that there are to be found upon various regions of the penis affections of which the diagnosis might be rendered extremely difficult by reason of the very peculiar aspect they may take on. It is thus that furuncle of the skin surface of the prepuce can under certain conditions take on absolutely the appearance of a syphilitic chancre. Here again the evolution of the lesion and the state of the inguinal glands must guide the physician in the diagnosis. The cancroïde, either observed upon the scrotum or upon the preputial mucous membrane, may simulate in a marked degree the initial lesion of syphilis ; but we may say that in general the diagnosis is only difficult when it must be made at the first examination, without being able to watch its course.

*Sclerosis of the glans* is the name which Mauriac has given to a special induration quite different from that observed in syphilis, at points where chancres have had their site. This form of hardening of the tissues may be found after simple chancres, blennorrhagia, or any inflammatory condition not associated with syphilis. It is an induration of the glans which produces thickening of the mucous membrane and even augmentation of volume of the organ. The change in structure which takes place in the glans predisposes it to various lesions, such as ulcerations and gangrene.

This balanic sclerosis is most commonly consecutive to a chronic blennorrhagia, although this latter must not of necessity have been particularly violent to cause the disease. It is probable that there exists a particular individual predisposition, similar to that which we observe in certain persons, who, following slight irritations, present congestive spots in the neighborhood of the orifices, as the lips and nose, which last for a long time.

The hardening of the glans may be so marked as to resemble cartilage, and be accompanied by an enormous increase in size. Subsequent ulcerations and gangrene may cause numerous fistulous tracts.

There is a serious difficulty encountered in diagnosis, for at first it seems that such hardening must be symptomatic of an infecting chancre located within the urethra. In simple induration, the induration is always symmetrical, occupying, in an equal degree, both sides of the meatus, whereas in chancre it is much more

irregular. Here again the state of the inguinal glands is of the greatest importance, for in simple induration they are never involved.

Finally, although exceptional, non-virulent ulcerations of the genital organs hold a sufficiently important place in this special part of pathology not to be neglected in diagnosis. The physician should not regard all lesions as of necessity specific or virulent because they occupy the genital organs.—*Journal de Médecine et de Chirurg.*, July, 1886.

### HARD CHANCRE OF THE VAGINA.

AN exquisite case of hard chancre of the vagina is related by Dr. Bockhart, in the *Monath. für pract. Derm.*, No. 12, which is interesting from the manner in which it originated, as well as from the fact that the hard sore is very rarely found on the mucous membrane of the vagina, partly because of its histological formation and because, too, sores here heal quite rapidly. A woman who had never before contracted syphilis, although she had often had coitus with an infected man, experienced pain after each connection during the fortnight before she was seen, and after each intercourse drops of blood came from the vagina. Examination showed an undoubted hard chancre in the middle of the posterior vaginal wall. There were no secondary symptoms. The man had moist patches about the frænulum. The origin of the infection was this: The man, who was in the habit of performing the act several times during the night, always used at the first onset a so-called *stimulating condom* to increase the woman's genital excitation, and left it off during subsequent copulation. The instrument mentioned consisted in a thick rubber condom having rows of rubber prongs on its surface so arranged that they flatten out as the penis enters the vagina, but upon withdrawal stand out and irritate the vagina, and, undoubtedly, when often used, cause erosions. An erosion having been produced in this way, the syphilitic virus found entrance from the man's mucous patches, and the perfect induration resulted, where, without the loss of substance, spontaneous healing would have been looked for. Symptoms of constitutional syphilis soon appeared.

### LOCAL BATHS OF CORROSIVE SUBLIMATE IN THE TREATMENT OF CERTAIN SYPHILIDES.

IN a communication to the French Society of Biology, June 10th, 1886, *Le Progrès Médical*, Dr. Gilles de La Tourette claims excellent results from the use of baths, and local applications of corrosive sublimate solutions in plantar and palmar syphilides, especially those resembling psoriasis.

The author had observed the success of this treatment at the St. Louis Hospital in 1880, as employed by the late Dr. Hillairet, in generalized papulo-squamous syphilides. Kaposi has recommended this same treatment, advising solutions of the strength of one gram to each one hundred grams of water.

This strength has seemed to the author too irritating in many cases, and almost intolerable where fissures are present.

He considers Van Swieten's solution (Hydrarg. bichlor., Ammon. chlorid., ãã gr. x.; Aquæ, Oi.), diluted one-half, quite strong enough for most cases. The results of treatment in sixty-five cases are recorded, and interesting observations given. These lesions on the palms and soles appear usually in the first six or eight months after the disappearance of the chancre, and are benign if the disease is receiving proper treatment. When, however, these lesions first appear from five to eight years after a primary syphilis where treatment has been neglected, they are not so mild. The palms and soles, especially the latter, become

covered with hard crusts, and the natural creases and folds become fissured and exuding and are painful. A sensation of heat is felt in the palms and soles, especially at night.

The treatment for both forms is the same, and a local bath of ten minutes' duration, morning and evening, suffices to cure in ten or fifteen days an eruption which has resisted internal treatment for six weeks or two months. In three very obstinate cases, one of which had lasted for two years and a half, despite all treatment (anti-syphilitic not having been tried), the employment of the local baths demonstrated, by a rapid cure, the specific nature of the disease which had up to this time been ignored. This mode of treatment is then at once curative and diagnostic, and should not be neglected in doubtful cases.

It has appeared to the author that baths given as hot as possible gave better results than cold local applications. With regard to the contagiousness of the exudation from these palmar fissures, he states that it is difficult not to so regard it, when we know the contagiousness of mucous patches, which are of much the same nature, being the papulo-erosive lesions of the mucous membranes co-existing with papulo-squamous lesions of the skin.

In conclusion, the statement is made that this treatment was applied to a case of erythematous lupus which had existed for six years upon the knee of a young lady of eighteen. The cure was completed at the end of two and a half months.

### DIAGNOSIS BETWEEN THE INITIAL SCLEROSIS OF SYPHILIS AND LOCAL CONTAGIOUS HELCOSE (SOFT CHANCRE).

DR. ERNST FINGER (*Vierteljahrsschrift f. Dermat. und Syph.*, 1885) lays down the following propositions concerning hard and soft chancres and their diagnosis.

From the observations of others and from those of the author himself, he believes that induration of a primary sore is not a positive sign of syphilitic infection and should not be so regarded. Induration is found in secondary and tertiary lesions, and also in inflammatory infiltrations in syphilitic individuals.

Again, non-syphilitic affections after various irritants take on a decided induration at times. Finger, therefore, concludes that induration is not an absolute pathognomonic sign of the initial lesion of syphilis; its presence being no more a positive sign than its absence a sure negative symptom. Entire surety of the syphilitic nature of an initial lesion is first possible (confrontation being excepted) when the indolent glandular swellings appear, that is to say, in about three weeks after the infection.

Now according to the author, from the nature and mode of increase of micro-organisms, and consequently of the syphilitic virus, it is physiologically improbable that the disease should remain localized for three weeks, and consequently he does not favor the excision of the local sclerosis.

From the results of recent inoculations, Finger endeavors to uphold the belief that a soft chancre can be produced in healthy persons by the inoculation with pure pus. Inoculations on the genitals from non-syphilitic traumatic ulcers produce on the individual himself, as well as on others, typical soft chancres. This quality seems to him to depend really upon the seat of the original ulcer upon the genitals, where the virulence is increased by the uncleanness so commonly found. In opposition to the objection of dualists that syphilis, often only a local affection, produces soft chancre, he opposes the fact of the well-known immunity of certain individuals—an immunity which is observed in those who have passed through acquired or hereditary syphilis, and in healthy



children of syphilitic parents, as also an immunity against syphilitic virus which has not yet been explained.

### HOMŒOPATHIC TREATMENT OF RHUS POISONING.

MR. TAFEL, in the *Homœopathic Recorder* for July, says: "While there are ever so many antidotes, no remedy has as yet been found successful in all cases of poisoning by Rhus."

The writer has had considerable experience with the effects of the plant on the skin of his employes, who collect the yearly supply of fresh leaves for the pharmacy, as well as in others. In 1871, a five-year-old boy who had crept through some Rhus tox. brushes became so poisoned that the face was swollen and the eyes closed, and the abdomen and genitals were implicated. On the third day, in spite of all remedies, the face was covered with a thick gray crust. Two doses of *Psorinum* 400 (Hering) were given four hours apart. Within an hour the itching grew less. Next day the crusts died, and in three days they were gone and the boy was soon well. In his own person, where the face was puffed up and itchy the morning after gathering the plants, he took one dose of the 28,000 potency of Rhus tox. Within less than an hour his face felt as though a cooling lotion had been applied, and by evening the swelling was almost gone.

The boy of five, previously mentioned, was a second time poisoned; the face, neck, hands, and arms being "blotched with a terribly itching eruption; he received *one dose* of Rhus tox. 28,000 potency, and by evening the face looked natural and the itching was gone." He subsequently treated three cases with this same strength of the Rhus, giving only two powders, and "within twenty-four hours they had been cured and stayed cured." The next season, he says, when he wanted to repeat this success, the remedy, for some unknown reason, would not respond, and that season he saw as prompt effects in several cases from *Bryonia* 200. However, he considers *anacardium* 200 and *croton tiglium* 200 as the standbys.

This year Mr. Tafel says four of his men gathered, in one day, two hundred and sixty pounds of fresh leaves. Each man and the superintendent took, before starting, a dose of *anacardium* 200, and a second dose upon their return. Two men escaped entirely; one had a slightly inflamed face the next morning, but after a third dose the redness decreased, and on the third day he was well. The superintendent was slightly affected on the wrists and arms; he took three doses of *anacardium* and was well on the fourth day.

*Bryonia* is said to remove the sensation of fulness in the scalp, the rheumatic pains in the chest increased by respiration, palpitation, dyspnoea, and painless rigidity of the neck.

At the homœopathic pharmacy in San Francisco, they generally give the third or sixth potency of Rhus Californica as an antidote, with apparently good success.

### THERAPEUTICAL ACTION OF ALVELOZ.

DR. LANDOWSKI has devoted considerable study to the therapeutical action of the juice of alveloz, the Brazilian remedy for cancer. His experiments have extended over a period of one and a half years, and from their results he draws the following conclusions:

1. This preparation is worthy of a most careful experimentation; it unites with a powerful escharotic action the property of dissolving organic tissues, and its action may be compared to a powerful caustic, double the strength of papaine.

2. The destruction of pathological tissues is promptly effected, and may be graduated, so to speak, layer by layer. The juice may then be employed when, from any cause, the bistoury is not practicable.

3. The application of the new topic is quite convenient, the most powerful effects may be obtained by simply painting with a brush. A dressing with a solution of the sublimate (1 to 2,000), or borated vaseline, may afterwards be made.

4. In order to obtain the desired effect, the juice should be fresh, since it rapidly loses its properties.—*Bull. Gén. de Therapeutique*.

### THE THEORY OF SYPHILITIC INFECTION OF THE MOTHER BY THE FŒTUS.

SOME three years ago, Dr. Roig Bofill read a paper before the Royal Academy of Medicine and Surgery of Spain, in which he took the ground that syphilis could not be communicated from the foetus to the mother, basing his views upon the anatomical facts opposing such a theory. Recently Dr. Charles Shadck has published, in Kieff, a brochure in which he also endeavors to refute the theory of the *choc en retour*, or syphilis by conception. The author believes this theory, advanced over sixty years ago by Gardien, has held its ground simply from the fact that its opponents have contented themselves with a simple negation, instead of citing proofs and of submitting the assertions of the partisans of this theory to rational criticism. He asserts that the examination of the mother in such cases shows conclusively that the lesions are of greater age than they could be, had the disease been acquired from the foetus. He says also that no facts have ever been brought forward to show that solid substances or formed elements can pass from the foetus through the placenta into the maternal circulation. And as at the present time it is admitted that syphilis can be transmitted only through the medium of formed elements, he says, it is therefore highly improbable that the child, while still in the womb, can communicate the disease to its mother.—*Revista de las Ciencias Médicas*, August, 1886.

**COLLODION IN VARIOLOUS ERUPTIONS.**—At a recent meeting of the Société des Hôpitaux, M. Comby stated that the different local remedies which from time to time have been recommended for arresting the variolic eruption, have all in their turn been rejected as dangerous. He mentioned the following case as an example: A female patient entered the St. Louis Hospital with small-pox. Her face was covered with collodion. Papulæ appeared on the trunk and limbs; the face seemed to be free from eruption. On April 11, papules appeared on the upper lip and raised the collodion. The eruption spread entirely over the face, and showed through the covering of collodion. The patient suffered intolerable agony. An attempt was made to remove the collodion, but the patient suffered such pain that it had to be given up. The portion of collodion that was separated from the face left the derma exposed to the air. The eruption, which was discrete, semiconfluent, extended to the limbs; and the face was transformed into a running wound most offensive in its odor. The temperature rose to 39.4° Cent. (102.3° Fahr.). On April 15, the patient became delirious, and died. M. Comby considers that the patient died from the same morbid process that kills patients with serious burns. At the necropsy, all the viscera were found to be healthy. If the patient had not died, she would have been terribly disfigured by buccal or palpebral atresia.—*British Med. Journal*.

JOURNAL  
OF  
CUTANEOUS AND VENEREAL DISEASES

---

---

VOL. IV.

DECEMBER, 1886.

No. 12.

---

---

**Original Communications.**

---

NOTE RELATIVE TO THE BULLOUS ERUPTION OCCURRING AFTER  
INGESTION OF THE IODIDE OF POTASSIUM.

BY

JAMES NEVINS HYDE, M.D.,

Professor of Skin and Venereal Diseases, Rush Medical College, Chicago.

AT this date, it is almost necessary to introduce a discussion of the particular subject to which this note refers, with an apology. In the year 1879, following the late Drs. Tilbury Fox, and Bumstead, Dr. Taylor, and others, I read before the American Dermatological Association a paper entitled "A Contribution to the Study of the Bullous Eruption Induced by the Ingestion of the Iodide of Potassium."<sup>1</sup>

Since that date, valuable contributions to the same subject have been made abroad by Thin,<sup>2</sup> Hallopeau,<sup>3</sup> Lindsay,<sup>4</sup> Besnier,<sup>5</sup> and Pellizari.<sup>6</sup>

In our own country, exceedingly interesting and important papers bearing more or less directly on the same theme have been published by Drs. Van Harlingen,<sup>7</sup> Morrow,<sup>8</sup> and Tilden.<sup>9</sup>

<sup>1</sup> Archives of Derm., October, 1879.

<sup>2</sup> Medico-Chirurg. Trans., 1879, p. 189.

<sup>3</sup> L'Union Médic., No. 41, 1882, p. 481.

<sup>4</sup> British Med. Jour., March 19, 1884, p. 602.

<sup>5</sup> Annales de Derm. et de Syph., March, 1882, p. 168.

<sup>6</sup> "Nuovo Contrib. allo studio d. Eruz. Iodiche." September, 1884; also Arch. of Derm., July 1, 1881, p. 267; and eleven other journals named by the author.

<sup>7</sup> Arch. of Derm., 1880.

<sup>8</sup> JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, December, 1884; April and May, 1885.

<sup>9</sup> Reprint of Report made to the Annual Meeting of the Mass. Med. Soc., June 9, 1885.

It is quite unnecessary to retrace the ground well covered by these writers, and scarcely needful to add to the list of clinical facts already recorded, which demonstrate the main point, viz., that ingestion of the iodine compounds is occasionally followed by the appearance of a bullous exanthem.

This note relates to a single point of interest in this connection, and the following cases are narrated in the briefest form merely to illustrate what follows :

CASE I.—On the 15th of March, 1886, a fairly well nourished female infant, 7 months old and suckled by a pallid-faced mother, was presented for examination. Its previous history was submitted in writing by the physician in the town where the family resided. According to this account, six weeks before, the child had suffered from a fever the exact nature and origin of which was not known. Three weeks before the present date, the eruption now visible appeared first on the neck, and then gradually spread over the face, scalp, and dorsal aspect of the hands and forearms. The lesions at first resembled those of chicken-pox, some rapidly desiccating; others persisted and enlarged. Before and after the appearance of the eruption, the iodide of potassium had been administered in one-grain doses.

When examined, the child's face, the dorsal aspect of the hands and forearms, and, to a less extent, the scalp were found covered with isolated, whitish and reddish-yellow, split-pea to marble-sized, firm, flattened, and slightly umbilicated lesions, resembling molluscous tumors. A few looked rather like vesicles. The two upper limbs were nearly similarly affected, but there was decided asymmetry of distribution on the face. The contents of these singular lesions were inspissated, thick, grumous, and of such consistency that there was no escape on rupture of the containing wall. They showed no trace of iodine when chemically tested.

A single and remarkable lesion existed on the left cheek. It was as large as the longitudinal section of a turkey's egg, flattish, ovoid in contour, with a narrow areolar blush, and raised about six millimetres from the surface. It had rather the lighter of the several shades presented by the eruptive lesions, being milky-whitish in color. It was evidently constituted of a group of lesions of the kind to be seen upon the hands. This patch had a remarkable, deforming, and formidable appearance, and would have aroused my anxiety if I had not, after its examination, felt confident that I had before seen such lesions disappear under very simple management. There were a few less perfectly developed button-like vesicles on the upper and anterior face of the trunk.

The eruptive lesion in this case were dusted with an antiseptic powder, and the nursing mother was given a ferruginous tonic. In two weeks more, a letter was received from the father from which the following is an extract:

"The spots have all dried up; only a slight redness of the skin remains where they once were."

Regarding the tender age of the child, it was not deemed justifiable to experiment in the reproduction of the eruption by a repetition of the



dose. The examination of the urine passed upon a napkin was negative as regards the presence of iodine, but not satisfactory as to the quantity and character of the specimen secured for examination.

CASE II.—On the 4th of February, I was summoned to the Hospital to pronounce upon several cases of disease of the skin. Among the patients was a cachectic-looking, poorly-nourished, sallow-faced lad, 15 years old, who had lately undergone a surgical operation for necrosis of the right femur. He was completely stripped, save as to the surgical dressing of the limb upon which the operation had been performed, and his body was then seen to be quite regularly and generally covered by eruptive lesions of two kinds. That which predominated decidedly as to extent and vividness was composed of large annular and circinate plaques, dull-red in shade, with a more or less clear and unaffected centre, extending, with diameters varying from several centimetres to a half metre or more, over the trunk and limbs. In a few well-marked areas, the centre was not clear, but occupied by a dull-red, diffusely infiltrated and raised, scarlatiniform patch, with defined circular or ovoid outline. In some parts, the eruption was of a dull brownish hue, these colors changing markedly during a hystero-epileptoid convulsion occurring during the course of the examination, at which time the patient partially lost consciousness.

Besides these extensive giant areas resembling certain forms of erythema circinatum here and there, more particularly about the fingers and hands, though elsewhere also, were distinct blebs. These were pea-to small nut-sized, destitute of areolæ, globular, well projected from the level of the surrounding integument, and, for the most part, of light-bluish leaden color, containing, in every case when not ruptured, a clear serum. After rupture, there was left in those whose history had been traced for several days dark-reddish, pea-sized, and somewhat smaller circular maculations where repair occurred beneath superficial crusting. Some of these vesicular and bullous lesions were found in connection with the scarlatiniform plaques of circular outline; others, however, occurred where there had been no involvement of the skin by any pathological process.

I asked, as soon as the examination of the patient was concluded, whether the iodide of potassium had been exhibited in his case, and was told that no medicine of any kind had been given. It was natural then to look for an exciting cause in the antiseptic dressings applied to the wound of the thigh; but while investigating this subject, one of the internes was called aside by the nurse, who told him that the patient had been kept steadily on the iodide of potassium in fifteen-grain doses ever since the eruption appeared, and but a brief time before. I did not hesitate to decide as to the origin of the exanthem on this showing. In a week after the discontinuance of this drug, the eruption faded completely, and was reappearing in the same form on a second exhibition of the potassic iodide in the former doses, when he was removed by his friends from the hospital.

In this case, iodine was found in the urine, but none in the contents of the vesicles and bullæ.

My personal observation of the eruption now under consideration has

been limited to the facts described above, with a single and not unimportant exception which, unfortunately, I am not justified in reporting as having been carefully observed.

In the year 1880, I was passing the office of a physician who was also a personal friend, when he called me to step inside for a moment, not with a view to a consultation, but because he had a child in his arms whose face and hands were covered with such an "unusually abundant crop of mollusca" that he wished me to see them. I was in the room for but a moment, yet in that time I could observe that the child was healthy looking, and about two years old, with face and hands thickly studded with small marble to pigeon's egg-sized, firm, reddish-yellow, slightly umbilicated, semi-solid lesions, with contents of the so-called sago-grain type. As soon as my eyes rested on this eruption, I detected its resemblance to that described by me in my paper written during the preceding summer. I told my friend that the case was not one of molluscum, and asked whether before and since the first appearance of the eruption he had administered the iodide of potassium. He confessed that he had done this for relief of another ailment. As the mother was waiting, I had but a moment in which to complete the interview. Later, this physician informed me that the eruption disappeared, undergoing involution by the formation of crusts, after the drug was discontinued.

I note it as a curious fact that no one of the physicians in the cases described above, when confronted with this singular eruption, seems to have had the remotest suspicion that it had resulted from his prescriptions.

On the basis of this confessedly limited experience, it is of course improper to draw positive conclusions. I am, however, as a result, impressed with the conviction that the writers on this subject have confounded different forms of eruption, and that, sharing their error, I have myself contributed to the confusion. Certainly two distinct and different types of bullous or quasi-bullous eruption have been produced by ingestion of the iodide of potassium under my observation; and if the polymorphous rash be regarded as distinct, which I am not sure that it is proper to insist upon at present, no fewer than three sub-varieties or sub-forms must be admitted. The purpose of this note is to call such attention to this fact that subsequent observers, surveying the entire field with a view to its fresh study, may at least be awake to the possibilities of error. It should be added that, if any credit attaches to the establishment of a distinction of this kind, it is wholly due to the late Dr. Tilbury Fox. His early statements on this point somehow failed to attract the attention they deserved; and I, with others, have up to the present committed the error of ignoring the distinction he was early in making.

The first sub-form of bullous eruption induced by ingestion of the iodide of potassium is clearly of a bullous type, pure and simple. It is a noticeable and interesting fact that most of the cases tabulated under

this title are of this character. The patients are commonly well advanced in years, often decidedly cachectic, and affected with syphilitic or other grave disease. For example, of ten serious cases in this group, five proved fatal, and an equal number suffered from cardiac complications. The patients observed by Morrow, Thin, and Hallopeau may all be regarded as illustrations of the first and most common, purely bullous manifestation of the iodic exanthem. The pathogenesis of this affection, whether explained in one or another of the methods well-described by Tilden, cannot be entirely disassociated from the asthenic, cachectic, and even in cases almost moribund condition of the patient in whom the eruption appears.

In what may possibly be regarded as a second subform of this exanthem, there are di- or polymorphic symptoms. Here, more or less typically perfect bullæ are commingled with papules, tubercles, and scarlatiniform or other patches of disease. To this class may be assigned Pellizari's case, one of Morrow's cases, the second of those described above by myself, and possibly also a curious and very interesting case reported from the hospital practice of Dr. J. E. Graham, of Canada,<sup>1</sup> where the eruption consisted of numerous vesicles developed in connection with acute erythematous symptoms.

It is, however, to the third sub-form of eruption, hitherto regarded as identical with the others, to which I desire to call special attention. This is illustrated by Dr. Tilbury Fox's cases, one of which concerned a man only twenty-seven years of age; a very interesting case reported by T. Calcott Fox,<sup>2</sup> in the person of an eight months' infant; and the three children observed by me. Two of the latter were pallid, fretful, and poorly nourished, but were not in a state that could be properly described as cachectic.

Now, Dr. Tilbury Fox began his interesting paper by stating that the eruption under his observation was "quasi-bullous;" and this term is repeated by him several times in his paper. The plate he gives represents very perfectly the rash seen by me three times. This illustration is, however, far inferior to the well-executed lithograph reproducing the clinical aspect of the face and hands of Morrow's patient; and, as stated by me in my first contribution to this subject, is wholly unlike the Sydenham Society's plate, entitled "*Hydroa from the Iodide of Potassium.*"

Fox characterizes the eruption seen by him as "odd." In one, there was a suspicion of variola. The following are his significant words: "It

<sup>1</sup> The Canadian Practitioner, 1884, p. 255, "A Case of Hydroa with Peculiar Iodic Eruption." This paper seems to have been overlooked by Dr. Morrow in making up his statistics.

<sup>2</sup> Brit. Med. Journ., Nov. 21, 1885. This case also should have been included in Morrow's list.

is my opinion that the designations, bullous and pemphigoid, convey a most incorrect idea. The eruption is not made up of true bullæ, nor do the spots develop like true bullæ. The affection is in no way related to true pemphigus, or to hydroa as defined by Bazin who originally described it. In the two cases, the particulars of which are here recorded, the eruption is said to have been papular in an early stage, and to have had, a little later, solid bases. In some parts they resembled acne simplex; in others, they vesiculated and subsequently simulated variolous pustules; at a later stage, ecthyma; and finally, bullæ with milky contents, or discharging smegma; and these bullæ possessed peculiar solid bases wholly unlike true bullæ; answering rather to large molluscum contagiosum tumors with semifluid instead of more solid contents."

In yet other parts of the same paper, the writer describes the lesions recognized by him as a kind of "papillomatous growth," "a white pul-taceous, fungatory mass," "spots" filled with "excessive and altered secretion of sebum," and still other suggestive phrases.

Without apparently recognizing the fact that he was so accurately following in the footsteps of his predecessor, Dr. T. C. Fox, when describing the lesions appearing in the eight-months-old child under his observation, uses the term "condylomata" as one suggesting to his mind the appearance of the lesions. He also describes solid bases to the vesicles appearing on the surface, which had, precisely as in one of the cases here reported by me, been taken at one time for varicella.

Both of these writers employ the exact terms which might be used to describe the lesions seen three times by myself; and I deem it within bounds to add that they are expressions which would not properly apply to the eruptive lesions recognized by most authors who have described this exanthem. In none of the children seen by me were there true bullæ, of the kind described in the second of the two observations here reported. The lesions are all semi-solid, split-pea to small palm-sized in extent, filled with semi-pultaceous, sago-grain like, whitish to dark-yellowish contents, which would not flow freely forth on rupture of the roof-wall and in which their appearance very decidedly suggested umbilication. I now believe that I was in error when I stated in my former paper that this feature was due to collapse of the roof on the contents of the chamber after involution had begun. I am inclined to think that this appearance is characteristic of the special form of eruption under discussion, and due either to the tendency to grouping, or to follicular attachments of some portions of the epidermis overlying others in a different plane.

This much explained, I deem it safe to leave the question to be solved by further observation, which I feel confident will be had. I am aware



that personally I have seen this eruption but three times in my life ; but on the last occasion, so vivid was the impression produced by an earlier experience, that I felt morally certain, before the fact was known to me, that the iodide of potassium had been administered to the child, and was solely responsible for the apparently formidable results. I cannot believe that this same impression could be at any moment produced by merely inspecting bullæ on a child's skin. It is, of course, barely possible that the differences to which attention is here called are associated with the tender age of the subjects observed, but as precisely the same features were seen in the adult cases registered by Fox, I need not dwell on this point.

With this limited experience, it would be, of course, improper to formulate definite conclusions ; and I therefore summarize the suggestions advanced above, in the form of interrogative propositions as follows :

1. Are there not three sub-forms of the bullous exanthem developed after ingestion of the iodide of potassium in certain individuals ?

2. Is not the first and most common of these, to be generally recognized in persons of advanced age and cachectic condition, the rash being then exhibited in the form of typical bullæ ?

3. Is there a second, and still rarer sub-form in which the eruption is displayed in di- or polymorphic manifestation, typically perfect bullæ being then commingled with papules, tubercles, scarlatiniform maculations, or with other and different lesions ?

4. Is there not a third and rarer sub-form, a quasi-bullous rash, to be recognized most often on the face and dorsal aspect of the hands and forearms of infants and children ; where the lesions are semi-solid, slightly umbilicated, and filled with sago-grain-like, grumous, inspissated, yellowish, whitish, and darker-colored contents, which do not collapse after fracture of the encircling wall, but which, without distinct outpouring of the contents, may shrivel and desiccate to a crust after suspension of the drug inducing the eruption ?

5. Is this last-described lesion one to be recognized solely as the result of the ingestion of the iodide of potassium, never under other circumstances, and one as peculiar to the special condition it represents, as is the gumma to syphilis ?

---

**GONORRHEA FROM MALE TO MALE.**—In a recent number of the *Medical News*, Dr. Winslow reports an epidemic of an unusual nature occurring in an institution near Baltimore. One boy contracted gonorrhœa from a girl outside of the institution, and subsequently cohabited with a boy, causing an inflammation of the rectum. The fact that ten boys were found to be suffering from gonorrhœa showed to what an extent the filthy habit, to which some confessed, was prevalent.

## INFLAMMATION OF THE HAIR FOLLICLES WITHIN THE NARES.

BY

W. A. HARDAWAY, M.D.

I HAVE read with much interest in the October number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES an abstract entitled "Eczema of the Nares." While eczema of this region is common enough, and the description given by Kiesselbach is quite accurate, I agree with Dr. Moldenhauer in the statement that we have here to deal with two distinct clinical and pathological conditions, viz.: (1) eczema and (2) inflammation of the vibrissæ, which latter is in effect a folliculitis barbæ. I wish to speak of the latter very painful and annoying affection only. Although I had long possessed both a professional and—much to my regret—personal acquaintance with this really distressing malady, my first knowledge of the literature of the subject was made in the course of reading certain "Clinical Communications to Practical Medicine," contributed by Dr. (now Sir) Dyce Duckworth to the St. Bartholomew's Hospital Reports, vol. xv., 1879. In this place, speaking of the great value of glycerin in painful forms of follicular inflammation of the skin, he remarks that "in particular there is a form of follicular inflammation, not uncommon about the nostrils, where poultices cannot be applied. A sort of "blind boil arises in connection with the vibrissæ, accompanied by intense pain and tension. Suppuration is not common, and resolution occurs as a rule. The application of pure glycerin, by means of a camel's-hair pencil, both internally and externally, is a source of much relief and comfort."

It is likely that there are a number of etiological factors that enter into the production of this affection, but I wish especially to call attention to the frequency with which it seems to be associated with a broken-down state of health. I have noticed it quite often as a consequence of a "fagged-out" condition of mind and body, following upon unusual or prolonged mental activity. The pain may in some cases be very severe, the parts feeling as if a burning coal were being held to them. The acuteness of the suffering is due to the fact that in these cases we have an inflammation of the hair follicle in a place where there is little room for the extension of the inflammatory process; the parts are rigid and do not readily yield, and give rise to the same symptoms that occur when an abscess affects the palmar or plantar regions. The skin of the nose, such is the intensity of the inflammation, also becomes intensely red, and at the end of the process not infrequently desquamates. Suppuration is comparatively rare, and the disease may last from a few days to several weeks; in some

cases creeping along, now and again a new follicle becoming involved, for months. In these chronic cases, the patients will often consult you for the external redness, not connecting it with the inflammation about the vibrissæ.

As regards the internal treatment, and such treatment I have found nearly always to be necessary, it is well to correct any obvious errors of health, especially inquiring into matters of digestion, and then to institute a general tonic course. The following combination has appeared to me particularly serviceable :

℞ Ol. morrhuæ.....fl. ʒ iv.  
 Pancreatin saccharat.... 3 i.  
 Pulv. acaciæ.....q. s.  
 Glyceriti hypophosphiti,  
 Syr. calcii lactophosphatis,  
 Aquæ.....āā fl. ʒ iv.  
 Ol. gaultheriæ.....gtt. xxx.

M. et ft. emulsio. S. Tablespoonful three times a day after meals.

I generally precede this, however, with the sulphide of calcium for a few days, giving one-tenth grain every third hour. If the case is seen early, this latter treatment is undoubtedly serviceable. In the local management of the acute stage, I have taken advantage of Sir Dyce Duckworth's suggestion as to the utility of glycerin, and, I think, improved upon it. Instead of using glycerin pure, I add to it two drachms of Squire's glycerole of the subacetate of lead.<sup>1</sup>

This I direct the patient to apply freely, by means of a hair pencil, to the inside and outside of the nose. At the same time I recommend the parts to be fomented several times a day with water as hot as can be borne. I also regard it of much moment that the hairs be plucked from these inflamed follicles—a proceeding which often goes far towards abating the process. When suppuration occurs, the knife should be employed, and sometimes, even in the earliest stage, free local depletion serves a good purpose.

After the pain and tension have greatly subsided, there remaining only much soreness and external redness, I am in the habit of employing the following ointment, which I first saw in Van Harlingen's valuable and practical handbook, where it is recommended in certain forms of eczema :

<sup>1</sup> The formula of this valuable preparation is as follows : Acetate of lead, 5 parts ; litharge,  $3\frac{1}{2}$  parts ; glycerin, 20 parts, by weight. Mix and expose to a temperature of 350° F., and filter through a hot-water funnel. The clear, viscid fluid resultant contains 129 grains of the subacetate of lead to the ounce.

℞ Squire's glycerol. plumbi subacetat.....fl. 3 ss.  
 Glycerini.....fl. 3 iss.  
 Ung. aq. rosæ..... $\frac{5}{8}$  i.  
 Cerae albæ.....q. s.

M.

Finally, when the hairs in the nostrils are not too numerous and are quite large, and when this annoying disease is prone to numerous relapses, it may be advisable to destroy the vibrissæ by electrolysis.

2303 Olive St., St. Louis, Mo.

## ON THE VALUE OF ARSENIC IN THE TREATMENT OF DISEASES OF THE SKIN.<sup>1</sup>

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

**T**HOUGH I cannot indorse the general tenor of and inferences to be drawn from Dr. Fox's article, "On the Useless Administration of Arsenic in Diseases of the Skin," I think we have reason to be pleased with the condition of affairs which prompted its publication. While he justly calls attention to its too frequent routine use, and draws the line, I think, too closely around its sphere of usefulness, he by implication shows that to-day our resources in the treatment of diseases of the skin, in the way of topical, hygienic, and thermal adjuvants, and medicinal agents, is so great and measurably precise, that we are in a position very far in advance of our predecessors, and that we can afford to look calmly and critically on the therapeutic effects of this remedy, and seek to determine, as nearly as possible, what it will and what it will not do. While my studies of the doctrines of the various schools of dermatology have taught me that local causes play a large, if not the most important part in the causation of skin diseases, I have not lost sight of the fact that various systemic or internal conditions do exist as etiological factors in them, and that treatment should be based on broad grounds rather than on narrow and exclusive ones. Therefore, while I employ all the most approved topical remedies, I invoke the aid of internal agents where they may be useful. Permit me, therefore, in this present symposium, to add my mite, and to briefly state my results with arsenic in the treatment of skin diseases.

In general, I think arsenic is of value in the more superficial affec-

<sup>1</sup> Read before the N. Y. Dermatological Society, October 25, 1886.



tions, particularly in those of the epidermis, in those having a neurotic origin, and it is particularly beneficial in cases—not infrequent—in which malaria acts as a complication.

I have observed marked benefit in many cases of acne simplex, either alone or in combination, as the case required, with alkalis, iron, and tonics. In some cases of acne indurata, it also has been of decided value, while I have found little benefit from it in rosacea.

In my experience, the value of arsenic is, I think, most strikingly shown in its effect on certain lesions of a scaling hyperæmic character and of neurotic origin. The limits of this paper will not permit me to give the facts in detail which are to be found in an article by me, entitled: "On a Peculiar Ringed Affection of the Prepuce and Glans," *Archives of Medicine*, page 237, Vol. XII., 1884. A perusal of the results obtained by the use of arsenic in those cases will, I think, convince a skeptic of its great value.

In pemphigus, my experience has been in accord with Hutchinson and others as to the decided beneficial action of this agent, and I recall several severe cases of herpes progenitalis of neurotic origin, in which marked amelioration of the symptoms and shortening of the course of the diseases was due to arsenic in full and quite long-continued doses.

While I have seen benefit from an alkaline treatment of lichen planus, I have seen many cases in which arsenic alone proved curative. In several instances of chronic and relapsing dermatitis herpetiformis, or dermatitis multiformis, it has proved the one agent which would abort and prevent the distressing outbreaks.

Our knowledge of the etiology and treatment of chronic urticaria is, to say the least, by no means precise, and we hail with delight any remedy of value. In several cases with marked features, I have seen much amelioration and even perfect cure from large and persistent doses of arsenic. Again, in an allied affection, erythema nodosum, arsenic has proved of decided value either as the active agent or as an adjuvant to iron or alkalis. In this connection I may say that it is in such cases as these, which are often rebellious and discouraging, that the great therapeutic power of this agent may be observed.

I am disposed to employ arsenic in a limited manner in the treatment of eczema, yet there are cases in which it will prove of benefit. In cases of spots of nummular eczema scattered over the body with a tendency to relapse, in some instances of eczema of the fingers and hands not caused by local irritation, chiefly in neurotic persons and those of poor fibre, I have seen markedly good results. Then again, in some few cases of erythematous eczema of the face and of eczema squamosum, I have seen it bring about a cure.

I think that the routine use of arsenic in psoriasis, and its consequent frequent failures, has much to do with the disrepute of arsenic, such as finds expression in Dr. Fox's article. There are many cases of psoriasis in which arsenic is positively harmful, if used in true therapeutic doses. I refer to those florid, plethoric cases in the adult and middle-aged, in which this stimulant of the cutaneous vaso-motor nerves is wholly out of place, and in which mercurial purgatives, aperient waters, and alkalies are indicated. My experience with arsenic in psoriasis teaches me that it is of value almost entirely in those cases in which the patches are of a pink color, often found in subjects who need tonics. I might enter into greater detail on this point, but want of space forbids it.

In syphilitic eruptions, particularly of the scaling papular and tubercular varieties appearing late in the first and in the second years and even later, arsenic will frequently prove a valuable adjuvant to mercury and iodide of potassium, alone or in combination. The same remarks apply to some forms of malignant precocious syphilides, and to the ulcerative forms of intermediary or late development. Stated concisely, I think it is of most value in syphilides attacking the derma more or less superficially, and of little value in infiltrations of the connective tissue. The existence of Donovan's solution is evidence that the value of arsenic and mercury combined was learned many years ago.

We certainly possess in arsenic an agent of much and extended value as an adjuvant to the iodides and bromides. It is needless for me to speak in praise of this remedy in preventing the unpleasant effects of these agents upon the skin. Who is there that has not had cases in which he would have been compelled to give up the use of iodide and of bromide of potassium but for the salutary effect of their combination with arsenic?

Though perhaps not germane to this contribution, I feel that this is an excellent opportunity to express my warm praise of arsenic as an adjuvant in some cases of persistent syphilitic adenopathy, both in the secondary and tertiary stages. Those who treat many syphilistics will call to mind cases in which the submaxillary and sublingual glands have become hypertrophied and perhaps sclerosed, and cases in which the cervical and inguinal ganglia have become enlarged and hardened late in syphilis—a condition very often attended with emaciation and cachexia. In many such instances, I have seen our usual remedies of no avail until their combination with arsenic, when the swellings have gradually melted away.

These are the most prominent instances which have made me a believer in the efficacy of arsenic. To be of value, it must be used carefully, intelligently, and persistently. Routine practice, in general, means care-

lessness, want of precision and slipshod diagnosis. Used in that manner, quinine, iodide of potassium, and the preparations of mercury themselves would fall into disrepute and disfavor.

I am not one of those who disparage Fowler's solution, since I have found it efficient in action and of easily adjusted dose. Arsenious acid and arseniate of soda in solution, pills, or in tablets, are also efficacious. The basis upon which the successful use of arsenic depends is, therefore, the care and accuracy of diagnosis, the intelligence shown in drawing the therapeutic indication, and the judgment, care, and persistence with which the remedy is handled.

40 WEST 21ST STREET, N. Y.

---

## Society Transactions.

---

### NEW YORK DERMATOLOGICAL SOCIETY.

166TH REGULAR MEETING, OCTOBER 26, 1886.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. SHERWELL presented a

#### CASE FOR DIAGNOSIS.

W. K., male, æt. 35. Now has an erythema covering the trunk and limbs, the face being entirely free. The eruption has appeared as a roseola about twenty days since, and about a week thereafter, a very marked desquamation occurred, almost severe enough to suggest psoriasis. Great pruritus supervened and is now occasionally present. Examination shows marked adenopathy, of inguinal, axillary, pectoral, and cervical glands. The patient gives no history of specific infection, nor of any other accident which might have a bearing upon the case. Careful examination shows no signs or remains of an infecting sore anywhere. There has been and still remains on all the sites of eruption pigmentation, which, however, is not marked in character.

DR. MORROW presented, on behalf of Dr. Fox, a case of

#### PEMPHIGUS,

or a bullous affection closely resembling it.

J. H., æt. 24; plumber; was in fair health until a year ago, when he began to suffer from "cramps in stomach," and his digestion has since been greatly impaired.

Six weeks ago, an eruption suddenly appeared on lower extremities, and a week later on arms. It was red, itchy, and elevated, and gradually assumed a dull or bluish hue.

Two weeks ago he had rigors and fever; left his work, and within past week

the bullæ have appeared, varying in size from a pea to a hen's egg, and for the most part seated upon the sound skin with no inflammatory areola whatever.

The patient appeared weak and ill. Upon removing clothing, large tense bullæ and small vesicles were found here and there upon the extremities, trunk, and neck. The face was entirely free, but quite large bullæ, without surrounding inflammation of the skin, were discovered upon the hands. Two weeks ago, just before the bullæ appeared, he had begun wearing new red flannel under-clothing. Local poisoning from the dye in the flannel was suggested as a cause of the peculiar eruption of bullæ; these, however, were found on parts not touched by the flannel.

The discussion of these cases was postponed, owing to the time required for the *special order of the evening* :

#### THE DISCUSSION OF THE VALUE OF ARSENIC IN SKIN DISEASES.

DR. PIFFARD said he considered arsenic a drug of great value, but the more localized the eruption for which it is employed the less will be the benefit derived.

In subacute forms of eczema, full doses must be given until the physiological effect is produced, and the dose then kept up to the limit of toleration.

In acute eczema, that dose would probably aggravate the condition, but if reduced to one-tenth or one-twentieth the ordinary dose, a useful effect will be produced. Like some other drugs, the effect of a large dose is decidedly the opposite of a small one. Thus, ipecac in large dose causes emesis, and in minute quantities represses it; opium in small dose excites, in large stupefies. Hence, Sydenham said of the drug *opium, sedat* ; but Brown, from his experience, was led to reply, *non sedat sed excitat*.

In acute eczema, a small dose of arsenic has a sedative curative effect, a large dose acts as a stimulant.

A small dose of ipecac is a stomach tonic; a small dose of arsenic is a skin tonic, a large dose an excitant. In practice he rarely prescribes a medium dose of the drug, it is either a large or a small one. He uses it constantly in chronic psoriasis of long standing, in cases where there is not much infiltration, but much epithelial hyperplasia. He cited a case of acute poisoning in the person of a patient with psoriasis, who accidentally took a drachm of Fowler's solution. The psoriasis vanished entirely within a few days. He has found arsenic of great utility in pemphigus. The changes after its use are too marked to cause any hesitancy in attributing the effect to the drug. The Germans deny its beneficial effect. It is probably useful in some of the other herpetic or large vesicular eruptions.

He cited a case of vesicular syphilide, about the diagnosis of which there was no question, and in which mercury and the iodide of potassium did not control the condition at all. Arsenic without any anti-syphilitic treatment was given a trial, and still there was no amelioration. A combination of the two was tried, and the vesicular formation was checked in a short time.

Arsenic is mentioned by one of the older writers as valuable in syphilis.

These diseases and acne are about the only ones in which it acts at all specifically. In cases having gastric and nervous debility, irrespective of the skin lesions, arsenic in small doses does good by bringing the system into a better condition by its tonic effect. Like other metals, such as iron, manganese, antimony, it is tonic in small doses.

DR. SHERWELL said: The limited amount of time allowed each member prevents me from considering Dr. Fox's propositions "*seriatim*." To generalize, however, I must strongly object to their general inference, which seems to deny the usefulness and what, in my opinion, is the extreme therapeutic influence of the drug *arsenic*.

The propositions themselves are somewhat vulpine in character, and some of them, and nearly all in fact, may be agreed to in part; but I must protest against at least their possible tendency to reflect upon the expert. I think certainly here the doctor's "*zeal for his house hath eaten him up*," and that his remarks are in



greatest measure intended for the general practitioner, and that not a good one; who, influenced by Hunt and his teachings, has followed that short cut to dermatology by the use of arsenical preparations in all cases and in all conditions. This is a fact which we are unfortunately often called on to deplore and correct, but the same rule applies, and in same degree, with mercury, quinine, opium, the iodides and bromides of potash, etc.

The doctor, it strikes me, is unhappy in the parallel he draws between its (arsenic) use and venesection, because I do not believe, as he seems to do, that this latter measure is useless, or at least not often indicated, abused, we all know it was, and has been.

I have availed myself of this means for rapid depletion on several occasions, when practising more generally than I now do, in cases of puerperal convulsions and the like, and have been well satisfied by results.

Ordinarily, depletion is now carried on by other means, as hyper-catharsis, etc., by hypodermic and other measures, so that nearly as quick results are attained by serous discharges, having absolutely the same, perhaps better, therapeutic effect; but still in the same direction. Depletion is now employed in very many inflammatory and other diseases, much as it has ever been.

As to the more or less specific action of arsenic in diseases having their seat or chief manifestation in the epiderm I am quite convinced. Every reason there is to believe that in neuroses of skin, and other affections of the same, having a malarial basis, it is equally effective. In that great archetype of squamous affections, psoriasis, I am positive, from actual experience, that its virtues are at least unexcelled by any one drug. I have used it alone sufficiently often for a fair test, and, although generally using adjuvant local applications in these cases, and often other medicaments of diuretic character, should feel lost without its aid.

Since the September meeting of the Society, I have had in my practice, private and clinical, beside old and relapsed cases, only two fresh cases of psoriasis, in both of which I have not felt justified in using arsenic alone; but all means, local and other, to produce speediest effect.

My colleague, Dr. Winfield, at Long Island Hospital Dispensary, has been more fortunate, however, and has had three cases: 1st, girl, æt. 9; 2d, male, æt. 45; 3d, adult male, age not given. By my direction and advice, he treated these cases with Fowler's solution alone. Result: No. 1. Child entirely relieved in fifteen days; No. 2. This second case, which was referred to me before treatment commenced, and which I have seen once since, exhibited the most extensive generalized eruption of a frank psoriasis I have ever seen, say three-fourths of the body and limbs affected; in somewhat less than three weeks, about seventy-five per cent improvement. The third case, time of treatment about three weeks, is approximately well. These somewhat remarkable and fortunate results were attained by gradually increasing doses of Fowler's solution from ℥iij. to ℥x. t. i. d., nothing else used or applied, not even simple unguent.

To sum up, while I do not claim arsenic as an absolute specific in all, or any one skin disease—in fact I doubt if such a thing as an absolute specific exists in medicine, I do believe that, in casting it aside or making light of it as advised, we should be doing away with what, with proper care, is the most powerful stimulant and therapeutic agent we possess.

DR. ALEXANDER said that his experience corresponded with that of Dr. Piffard. In chronic eczema and in psoriasis, arsenic was of decided benefit, and in acne was occasionally beneficial.

DR. MORROW said it had occurred to him that the results of the experience of a large number of physicians throughout the country, both specialists and general practitioners, would be of interest to the Society. In July last, through the pages of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES and other medical journals, he had requested information from physicians in relation to the general practice of employing arsenic in skin diseases, its superior value to other remedies in this class of affections, its ill effects, the preparation of the drug preferred, the doses employed, etc. In response to these inquiries he had received about seventy communications. The information contained in many of them was so meagre and indefinite as to be practically valueless. Many of the correspondents were non-committal, or expressed themselves in such general terms that their real opinions upon the points specified were largely conjectural. A tabulated statement containing an analysis of about forty of these letters in which the answers were for

the most part categorical, and contained definitely expressed views, based upon personal experience, was then read.<sup>1</sup>

Continuing, Dr. Morrow said that, as far as his personal experience was concerned, he had formerly used arsenic quite extensively in the treatment of certain forms of skin disease, but during the past few years he had employed it on a constantly decreasing scale of frequency. Formerly he was accustomed to prescribe it in almost every case of psoriasis, but of late years he had practically abandoned its use, save in exceptional cases, with the full assurance that he could cause the eruption to disappear much more rapidly and completely under the influence of local treatment. He had also lost faith in the efficacy of arsenic as a preventive measure. A large experience had convinced him that the drug did not exercise a positive influence in preventing a subsequent recurrence of the eruption.

He had used it in certain forms of chronic eczema, and in some cases with benefit, but, after all, he thought it probable that equally good results would have been obtained from the use of alkalies, cholagogues, and other measures calculated to correct the constitutional vice of which the skin disease was the local expression.

In a number of cases of pemphigus he had used it with advantage. He recalled a case of constantly recurring pemphigus he had presented to the Society, a few years ago, in which the administration of arsenic was followed by a most brilliant result. In one case of dermatitis herpetiformis, there was a marked improvement in all the eruptive features from the use of arsenic. He considered an annular configuration of a vesicular eruption a very good indication for the employment of this drug, but as a rule the indications for the use of arsenic should be drawn from the general condition of the patient. He protested against the practice of administering arsenic in all chronic skin affections, irrespective of constitutional conditions. It should not be given in psoriasis or eczema simply because the patient has these diseases and arsenic has been empirically recommended for their cure.

The true principles which should guide us in the therapeutic employment of this drug are, to give it in cases in which the general condition of the system seem to require this remedy, and in correcting the abnormal systemic condition, the cutaneous symptoms are correspondingly improved.

He was in the habit of giving arsenic in skin diseases in which a chronic malarial element was present, experience having shown that such cases are more amenable to the influence of arsenic than of quinine.

Advantage is also derived from the use of arsenic in certain forms of chronic erythema, acne, and rosacea, associated with a congested and catarrhal condition of the stomach. He was led to employ it in this class of cases from his observation of the remarkably good results obtained from small doses of Fowler's solution in the alcohol stomach. In correcting the morbid condition of the stomach, the coincident skin troubles speedily vanish. Arsenic possesses undoubted virtues as a neuro-tonic, and is applicable in all forms of skin disease associated with a lowered or impaired condition of cutaneous innervation.

DR. KEYES said he had little to add to the views he had already expressed before the Society, and embodied in a recently published paper in the *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*. He indorsed the views of Dr. Piffard and most of what Dr. Morrow had said, especially regarding the principle that the patient should be treated rather than the disease: he thought it a point worthy of being more insisted upon. Certain it is that some stomachs will not tolerate arsenic. The speaker had recently seen a case which, theoretically, should have yielded to arsenic, but did not, although the drug was pushed until the patient had been poisoned by it, and had lost eighteen pounds in six months' time. Coming under his care, he had stopped all drugs, and cut off the patient's tobacco and whiskey until his constitution was built up, when the eruption yielded to treatment. This procedure applies equally well to other drugs. Treat the patient as a whole, not relying upon the drug alone to do the work. One case of pemphigus, the speaker remembered, occurring in a lady of 60 years, and quite extensive, had yielded promptly to arsenic. A prolonged course of arsenic in small doses, when the stomach is in a suitable condition, does good in herpes, especially in recurrent herpes preputialis. He has found a little arsenic combined with mixed treatment

<sup>1</sup> See page 374.

beneficial in syphilis; noticeably in the erythematopapular and late secondary lesions. It also has a good influence in controlling the irritating cutaneous effects of the iodides. One or two drops of Fowler's with the iodide of potassium or sodium will often moderate the amount of iodic acne on the face, and assist in the digestion of the iodide. He does not know that it interferes with the effect of the mixed treatment. Guéneau de Mussy had called attention to the arsenite of soda as found in the water of the Bourboule Springs. De Mussy used it in the form of baths for fibrous phthisis and other diseases, as well as internally, and he believed with good results. The speaker now used arsenite of soda in preference to any other form of the drug, giving it in dose of from  $\frac{1}{10}$  to  $\frac{1}{2}$  grains— $\frac{1}{30}$  gr. being a fair dose. It is given in solution in water. It is combined with mixed treatment, and children take it readily. In conclusion, he thinks that arsenic is frequently exceedingly useful when the individual as well as the disease is studied, and the drug is not used in a routine way.

DR. ALEXANDER had used the Bourboule water, and found that it converted acute moist eczema into the dry form, especially in children, but that its value was limited. He gave usually half a wineglassful as a dose to a child.

DR. LEWIS had used arsenic in chronic eczema, especially in the infantile variety. He had carried out the suggestion made by Stephen Rogers many years ago, of commencing with a small dose and increasing rapidly until as much as fifteen drops of Fowler's was given to a child a year old. This is a larger dose than is usually given. He uses also the arseniate of iron in  $\frac{1}{2}$ -grain doses in uterine, malarial, and other diseases. As regards the local use of arsenic, he had employed it as a caustic in about one hundred and fifty cases of surface epithelioma, and is as strongly as ever in favor of it, and has on several occasions defended it as a caustic against the assertions of surgeons that it is a local irritant producing sloughing. Its action is rapid, circumscribed, and can be controlled and followed. It is, in his opinion, the best caustic which exists for surface epitheliomata which are not too large. He prepares Marsden's paste with two parts of arsenic and one of acacia, mixed up with a few drops of water. Marsden's rule, not to apply it to a surface of more than four square inches, is a safe one to follow. He has treated larger surfaces, but never over a square inch at a time. It may be applied in a thickness of nearly an eighth of an inch. The surrounding skin is protected with cotton, stuck fast to the paste. It is left on from twenty-four to seventy-two hours, and a poultice is then applied. It does not usually cause great pain. *He had never had a case of poisoning from its use in this way, but there are almost always constitutional symptoms.* He saw a decided paralysis in one case from its application to a cancer of the breast—a form for which, in his opinion, arsenic paste should never be employed. The absorbents are too active in cancer of the breast.

DR. STURGIS said the arseniate of iron in  $\frac{1}{10}$  grain doses he had found good in chronic psoriasis, in desquamating syphilides, especially of the palms, in urethral neuralgias, and irritable urethra generally. In squamous syphilides the preparations of arsenic come especially into play. He has found Donovan's solution an extremely good preparation, and agrees fully with the gentlemen who had spoken in favor of the combination of arsenic and mercury in the treatment of syphilis.

DR. MAYNARD, of Chicago, an invited guest of the Society, spoke of the abuses largely seen from the indiscriminate use of the drug. He has thought arsenic not indicated in acute disease, but has found it of much value in the more chronic scaly formations and, in one case in particular, of urticaria pigmentosa in a young child, its use was followed by very brilliant results. The child who had had the disease from the age of two months till it was a year old, was entirely cured and remains well. As to its external use, he has employed it in a large number of cases and regards it as the best caustic in the materia medica. He has applied it to some fifty cases of lupus, superficial epithelioma, and erythematous lupus and has never yet seen any evidences of poisoning.

DR. ALLEN said that the opinion which he had expressed at a former meeting of the Society, that arsenic was largely used in a routine way for all classes of skin diseases by many practitioners, distressing as the proposition was, he must reiterate, as being the result of his observation and statements made to him by practitioners. The first rule of therapeutics should be *to do no harm*. That arsenic is a potent drug capable of doing much injury when carelessly adminis-



tered none will gainsay. When improperly given, arsenic does harm, 1st, by not doing any good; 2d, by producing inflammatory conditions, other eruptions, intensifying at times existing pigmentary deposits in the skin, and producing them at other times *de novo*, and by producing toxic symptoms. To be of benefit the drug must be pushed in suitable cases to the point of toleration. In thus increasing the dose, great danger is incurred of producing symptoms of constitutional poisoning. In the experience of the speaker, a course of treatment must often be interrupted on account of the physiological effect of the drug. The tolerance acquired by Styrian and other arsenic eaters does not appear to exist for all people. In psoriasis he had occasionally seen good results from arsenic, but they were usually of a more or less temporary nature. The time to use arsenic in this disease he believed to be after the eruption had been removed by local treatment, or as it is on the decline, and the drug must be continued long in the interval of freedom from eruption. The Asiatic pill is the form he prefers for administration, and given in gradually increasing dose. He also uses at times the liq. potassii arsenitis, and the liq. sodii arseniatis, and often gives them in Vichy or cinnamon water before instead of after eating, a mode of administration he had learned from Dr. Bulkley, and had found, he thinks, to act more quickly and has not seen any bad effects on the stomach from it. He believed that the use of arsenic in acne was a common practice, but he had never seen much good result from it in this disease, except in a few cases in which the papules were small and few comedones present. In one case of lichen ruber in a young lady, the effect of arsenic appeared almost magical. The abuse of the drug in treatment is not confined to its internal administration. Arsenical pastes, which form excellent caustics when properly used, are much employed by irregular practitioners for the removal of morbid growths, tumors, etc., and not infrequently the most unfortunate results follow. A lady upon whom he operated for a lipoma of the thigh some months since had fallen into the hands of one of these Philistines, who had applied a paste in such a manner to the tumor to "draw it out by the roots" that in a few days the lady was taken violently ill, had an anxious expression, was very restless, had frequent vomiting, abdominal pain, frequent dysenteric stools, intense thirst, and a marked urticarial eruption quite generally diffused over the body. At the point of application of the plaster the skin was intensely inflamed, and several superficial sloughs formed. For several days she was quite ill, and did not wholly recover from the effects of her experience for several weeks. To use arsenic for its caustic effect externally, it must be applied in a concentrated form to destroy the absorbent properties of the skin so quickly that no constitutional effects follow. He had had several cases of arsenical dermatitis attended with slight constitutional symptoms although the lesions were extensive. Two cases occurred in longshoremen, the feet and legs being first affected, he was enabled to establish the fact that they had been unloading dry hides which are cured with arsenic. The arsenical dust had sifted through their clothing and low shoes producing bullæ, large vesicles, etc., followed by ulceration and swelling of the feet, legs, and hands. Papules and erythematous patches were scattered over the legs and thighs, attended with burning, itching, etc., etc. The speaker could not agree with Dr. Lewis that the pain from Marsden's paste was not usually severe. In his experience patients suffered intensely after its application.

DR. PIFFARD said the preparations almost invariably employed by him are the acid, combined with red or black pepper, as in the Asiatic pill. He had devised a powder combined with pepper which he called Asiatic powder, and had used extensively. All the peppers are of service in malaria, over which arsenic also has an influence. The old formula for the Asiatic pill, mentioned by the last speaker, included a drug called *mudar* or *Calotropis gigantea*, and he had had it prepared at times in this way. Fowler's solution he considered the least desirable form, and had never seen any advantage from the arseniates of iron, quinine, strychnine, etc. When these drugs are called for together, he gives arsenious acid and iron or quinine or strychnine, as the case might be, mixed with the arsenic, and not in chemical combination. He had advised the hypodermic use of arsenic in the neighborhood of localized lesions or diseased patches themselves when they were not too numerous, as the arsenic seemed to exert a more decided influence when thus locally used. This method of administration had been suggested by himself and a German observer at about the same time.

In epithelioma, he had made use of paste of his own, which he preferred to



Marsden's. He prepared it with equal parts of chloride of zinc and chloride of chromium, and enough arsenic to make a paste. He had found arsenical pastes to produce great pain which persists and causes severe suffering, great inflammatory reaction and swelling, more than other caustics. In contrast, the actual cautery produces the least, the hotter the better.

DR. MORROW said, in regard to the hypodermic use of the drug, that several of the correspondents who had answered his questions had given it up on account of the severe pain occasioned. Dr. Piffard answered that they had given too strong a dose.

Dr. Morrow did not wholly agree in regard to arsenic seeking out morbid tissues. The same selective action for diseased tissues had been claimed for lactic acid and other caustics, but careful experimentation had disproved such claims.

DR. PIFFARD said he had referred more especially to epitheliomatous growths.

DR. SHERWELL related a case of multiple sarcoma, which he had cured with Donovan's solution.

DR. LEWIS said that the pain from arsenical paste depended upon the location of the disease to which they were applied.

DR. TAYLOR'S remarks on closing the discussion are elsewhere published (see page 362).

---

## Correspondence.

---

### ARSENIC IN SKIN DISEASES.

*To the Editor of the Journal of Cutaneous and Venereal Diseases.*

DEAR SIR:—Having had considerable experience in the use of arsenic in skin diseases, and seeing the request in medical journals to physicians for answers to certain questions, I write my ideas as briefly as possible and hope they may be of some benefit.

First Question. No, I am not in the habit of prescribing arsenic "*generally*" in skin diseases; I formerly so treated my cases. I supposed the drug applied to many or nearly all skin diseases. As long as I followed this blind, theoretical idea, I had poor success in the treatment of cutaneous disorders. I certainly think that our text-books do not make sufficient distinction between those cutaneous diseases benefited by arsenical treatment and those which are not. Medical lectures are open to the same general objection.

Second Question. I have found arsenic the most beneficial in those cases of skin diseases in which there appeared to be a depraved condition of the blood or anæmia; in those cases where there existed evident cachexia, and where the skin appeared white and bloodless; diseases that leave the skin dry and scaly, with a surface which, when rubbed with the hand, sheds a bran-like scale. Thousands of practitioners call nearly every case of skin disease eczema, and prescribe Fowler's solution. This is not intelligent medical practice.

Third Question. I have often seen every symptom of the disease aggravated by the exhibition of arsenical preparations, notably those cases where there was plethora or a full habit associated with the disease. Where there are inflammatory symptoms, and the skin is red and capillaries congested, arsenic should not be given. In most diseases I do not pay much attention to symptoms, but try to find the cause of the disease, but in skin diseases I am governed very much by the symptoms—objective symptoms, in regard to what I prescribe.

Fourth Question. I generally prescribe the liquor potassæ arsenitis in skin diseases, because it affects the system quickly; but there are cases in which the sulph. arsenic either in solution or pill form, does better. In many cases benefited by arsenic the good results are secondary. The drug acts as an alterative

and tonic, improving the appetite, raising the nutrition, and of course indirectly acting upon the skin as the condition of the blood improves. Doses cannot be given, for every case shows a susceptibility of its own to the drug. I give it in sufficient doses to obtain the constitutional effects, and then lessen the dose a little and continue the drug, sometimes stopping it, and after a little giving again. I think external applications are not used enough or given sufficient attention.

Truly yours,

A. E. FARNHAM, M.D.

EAST MADISON, MAINE.

*To the Editor of Journal of Cutaneous and Venereal Diseases.*

DEAR SIR:—To a request in your editorial on "Arsenic in Skin Diseases" in JOURNAL OF CUTANEOUS AND VENEREAL DISEASES of July, 1886, I take pleasure in furnishing information upon the points mentioned, according to my own personal experience with the drug.

1. *Are you in the habit of employing arsenic generally in the treatment of diseases of the skin?*

No.

2. *In what forms of skin disease have you found arsenic of superior value to other remedies?*

In psoriasis; squamous eczema; in several cases of chronic acne, associated with gastric irritation; in some cases of chronic intermittent urticaria, in which other remedies used had failed; in several cases of persistent furuncular eruption coming out in successive crops.

3. *What ill effects have you observed from its use?*

Intense itching all over the body in a few cases, coming on principally when the patients get into bed, with dryness of the skin and furfuraceous desquamation about the legs and chest.

Herpes preputialis in one case, which always made its appearance after giving arsenic for a few days, minim doses of liq. arsenicalis (Fowler's solution) or liq. arsenici hydrochlorici B. P., producing it almost as rapidly as five-minim doses of either of the above preparations given three times a day.

A papular eruption about the face in one case, attended with a decided amount of pruritus; the papules, varied in size from a pin point to No. 4 shot, were discrete, and were more or less scaly upon their summit. The eruption disappeared after a few days, upon the discontinuance of the drug, and was followed by furfuraceous desquamation of the part affected.

4. *What preparation of arsenic do you prefer, and in what doses do you employ it?*

I generally employ Fowler's solution in one to five minim doses, or liq. arsenici hydrochlorici B. P. in one to five minim doses.

In one minim dose, I generally give it three times a day *just before meals*.

In five minim doses, *directly after meals*.

I frequently combine the liq. arsenici hydrochlorici with tinct. ferr. perchloridi, acid. phosphorici (dil. with glycerin and water), and Fowler's solution, with tinct. nucis vomicæ or liq. strychniæ, in suitable doses.

R. L. FAITHFULL, M.D., L.R.C.P.

43 PHILLIP STREET, SYDNEY, Sept. 7, 1886.

*Editor of Journal of Cutaneous and Venereal Diseases.*

DEAR SIR:—In response to your request, in the *Medical Record*, regarding the use of arsenic in skin diseases, I would say that I fully coincide with the views expressed by Dr. G. H. Fox in his recent article on the subject (*N. Y. Medica*

*Monthly*, No. 1). I, too, repudiate the routine practice of indiscriminately administering arsenic against diseases of the skin, as frequently done, even without proper diagnosis.

Being a pupil of Kaposi, and a strong adherent to the Vienna school, I always relied more upon the topical treatment, and only gave arsenic as an *adjuvant* wherever I believed it beneficial. Therefore, from my own experience I could not ascertain how much of the result was due to the arsenic alone.

Cases of lichen ruber, in which I would rely upon it principally, have so far not come under my observation in America, and I can judge about the excellent result against that disease only from my experience in Kaposi's service. In cases of psoriasis, I regularly prescribe it, fully confident of its effect, but even there never without contemporaneous external treatment (chrysarobin, pyrogallic acid, etc.); this is but natural in private practice, where a speedy result is desired. Besides, I sometimes gave it in cases of very chronic (dry) eczema, of pruritus, chronic urticaria, in a case of impetigo herpetiformis (Hebra), without, however, observing any *decided* beneficial result from its use.

In regard to its ill effects, I would say that I usually instruct my patients as to its possible bad influence, and have discontinued its use, or at least diminished the dose, whenever I noticed disturbances on part of the digestive organs, the conjunctivæ, etc. Only on a child, 5 years of age, which had taken Asiatic pills but a short time, decided poisonous effects (cramps, unconsciousness) were observed but soon disappeared after discontinuance of the drug.

As to the form in which I give it, I had, from my Vienna experience, a good deal of confidence in the so-called Asiatic pills; but, although I prescribed them in a smaller dose than given in the usual formula (from 0.25 to 0.50 ad pil. No. 100), I usually had to stop their use, on account of the bad effect on the stomach. Subcutaneous injections of Fowler's solution (4.00 ad 20.00 aq. dest.  $\frac{1}{2}$  to 1 Pravaz' syringe) were almost invariably followed by considerable local pains for many hours, even though all possible precautions had been observed; for this reason, I could not use them to any great extent.

Fowler's solution with aq. menthæ pip. (ââ) was always very well taken. Beginning with four drops of this mixture three times daily after meals, I usually could increase up to twenty drops (three times daily) without seeing any ill effect, afterwards decreasing again, and so on.

CHICAGO, ILL.

JOSEPH ZEISLER, M.D.

*Editor of the Journal of Cutaneous and Venereal Diseases.*

DEAR SIR:—In the July number of the *West. Med. Reporter*, page 272, will be found under the head of "The Useless Administration of Arsenic in Skin Diseases," most of my views on arsenic in skin disease; I offer this as answer to your interrogatories. I have no very decided ideas as to its *injurious* effects, however, but know that its continued use in increasing doses is fraught with danger to the constitution in general, and likewise locally to the digestive apparatus, the chief source of existence and health. While we all seem obliged at times to use remedies empirically, I am opposed on general principles to the indiscriminate, empirical, unscientific, and reckless use of any rank poison, more especially one of which I know no *positive* good. I may say still further, that I think I have seen erythematous conditions aggravated or produced by its internal use.

Most respectfully, etc.,

HENRY J. REYNOLDS,

*Prof. Dermatol., College of Physicians and Surgeons, Chicago, Ill.*

CHICAGO, ILL.

## THE VALUE OF ARSE-

	1.	2.
Klotz, Herman E., New York.	No .....	Alopecia simplex and areata, atrophy of nails, lichen ruber, lupus erythematosus, psoriasis, eczemas quamosum (simultan- eous application of external remedies).
Norton, H. G., Imlays- town, N. J.	Yes .....	Eczema and psoriasis.....
Young, E. G., Hazel- ton, Iowa.	Yes, generally..	In the different forms of eczema, most valuable drug in m. m. in all non syphilitic skin diseases.
Wessinger, J. A., Howell, Mich.	Habitually in certain forms of skin disease	Chronic and papular and squamous ec- zema, inflammatory condition accom- panying chronic indolent ulcer of leg.
Chenery, Elisha, Bos- ton, Mass.	Sheet anchor in limited range of skin dis- eases.	Psoriasis, other forms of skin disease in which the tonic effects of arsenic are called for; nearly a specific for any chronic eruption.
Bradbury, O. N., South Paris, Maine.	Yes .....	Eczema and those of kindred nature....
Brodnax, Benj. H., Brodnax, La.	In <i>all scaly dis- eases</i> .	Pityriasis capitis, eczema, lichen agrius, one or two forms of urticaria.
Chace, H. P., High- land Falls, N. Y.	Generally in ec- zema.	In late years, not at all, believing it ut- terly inefficient; best remedy we have in psoriasis.
Ross, W. S., Madison- ville, Ky.	Yes .....	All chronic affections of the skin.....
Daniel, F. E., Austin, Texas.	No.....	In no diseases found arsenic of superior value; used it with success in some cases of eczema where arsenic was in- dicated as a tonic; abused and over- rated remedy.
Woodbury, F., Phila- delphia, Pa.	Rarely use it....	In chronic skin diseases in which itch- ing is not marked.
Ohmann-Dumesnil, A. H., St. Louis, Mo.	No .....	In chronic squamous and tubercular dis- eases, valuable in skin affections de- pending upon neurotic troubles.
Putnam, F. W., Bing- hamton, N. Y.	No .....	Boils.....
Borchem, L. I., At- lanta, Ga.	Yes.....	Chronic eczema, especially in children; all scaly eruptions.
Eastwood, W. F., Claremont, Ont., Ca.	Yes; generally..	Chronia eczemas; boils, acne, psoriasis, chronic urticaria.
Jernigan, Chas. H., Enon, Ala.	Yes.....	All chronic cutaneous trouble.....
Getter, J. P., Allons- ville, Pa.	Formerly, yes; re- cently have lost faith in drug.	Chronic eczema; furunculosis.....
Rosenberry, H. L., Miltonsburgh, Ohio	No.....	Eczema, lichen, crusta lactea.....

Columns numbered 1 to 4, in answer to the following questions:

1. Are you in the habit of employing arsenic generally in the treatment of skin diseases?

2. In what diseases of the skin have you found arsenic of superior value to other remedies?



## NIC IN SKIN DISEASES.

3.	4.
Loss of appetite, dyspepsia, and similar disturbances of the digestive organs.	Fowler's sol. (gtts. vi. t. i. d. in German tincture of ferri pomati). Asiatic pills, 1 to 2 per diem.
None; sometimes too large doses temporarily aggravate eczema.	Fowler's sol. (gtts. i. to x.).
Temporary gastric and intestinal irritation.	Fowler's sol. (gtts. ij. and increase) in combination with a diuretic.
Conjunctivitis; in some cases, even from very minute doses.	Fowler's sol. (minimum dose, increased to maximum until full physiological effect, then reduce to minimum, and increase as before).
Untoward ill effects on eyes.....	Fowler's sol. (beginning 10 drops, 4 to 6 times a day, come down to 3 to 6 drops if ill-effects appear).
Nausea .....	Fowler's sol. (5 to 10 drops 3 times a day, and increase).
Of 197 cases, in 2% a rubeolous rash; in 20% puffiness of the face and dryness of the fauces.	Fowler's sol. (1 to 5 drops, increased 6 to 15 drops, increasing and decreasing, according to constitutional effects produced).
Intolerance by the stomach and trouble under the eyes.	Fowler's sol. (5 drops after meals, gradually increasing to 10 or 12). No bad effects from its long continuance when dose is carefully regulated.
None .....	Fowler's sol. (gtts. v. to vij. t. i. d.). If I suspect syphilitic disease, I give Donovan's sol.; same doses.
No ill effects .....	Fowler's sol., 5 drops, increased to 10.
None .....	Fowler's sol., small doses; arseniate of sodium, $\frac{1}{2}$ gr. combined with hydrochlorate of quinine; also Donovan's sol.
None .....	Fowler's sol., 3-drop doses with wine of iron; arsenious acid $\frac{1}{6}$ gr.; bromide of arsenic.
None .....	Fowler's sol., gtts. i.-v. t. i. d., after meals.
None .....	Fowler's solution.
Irritable stomach and headache..	Fowler's sol., gtts. ij.-v.; Donovan's sol., $\mathfrak{m}$ x. doses.
None from judicious use .....	Fowler's sol.; under certain conditions, prefer Donovan's.
.....	.....
Nausea and oedema of the face..	Fowler's sol., 10 drops t. i. d., after meals.

3. What ill effects, if any, have you observed from its use ?

4. What preparations of the drug do you prefer, and in what doses do you employ it ?

## THE VALUE OF ARSENIC

	1.	2.
Dennis, E. J., Bavaria, Kansas.	Yes .....	Urticaria, lichen strophulus, prurigo, impetigo, ecthyma, herpes, pemphigus, scabies, ambustio, gelatio, and various syphilodermata.
Browen, George J., Coovelo, Cal.	Almost universally.	Eczema and psoriasis.....
Marseau, L. T., Napierville, Can.	Yes, in all chronic skin diseases.	Eczema .....
Miles, George W., Oneida, N. Y.	Not only generally, but invariably in every case.	I cannot compare it with other drugs, as I never use anything but arsenic.
Halley, George, Kansas City, Mo.	Generally .....	In all cases where there is exudation, with infiltration into the cutis vera.
Le Hardy, J. C., Savannah, Ga.	Generally.....	Indispensable in chronic cutaneous diseases, and in eczema, herpes, etc., occurring in the course of syphilis.
Russell, C. P., Utica, N. Y.	Restricted to psoriasis, chronic squamous eczema, acne, and pemphigus.	In psoriasis, more especially the discrete forms.
Brown, J. S., New Market, Mo.	Invariably in chronic cutaneous disease non-syphilitic.	Never give other remedies, except in combination with arsenic.
Berry, J. J., Portsmouth, N. H.	Generally .....	In chronic forms of eczema, psoriasis, herpes zoster, acute or chronic.
Crawcaur, I. L., New Orleans, La.	Largely .....	Chronic eczema and psoriasis .....
Beach, Wooster, New York City, N. Y.	No .....	In chronic eczema; have little faith in arsenic.
Cross, Theodore P., Sun Prairie, Wis.	Yes .....	All diseases depending upon impaired condition of the blood.
Brush, R. H., Grand Eddy, Mo.	Extensively ....	In eczema, especially in infants, and psoriasis, has specific action.
Ensign, H. D., Boone, Iowa.	Yes .....	Anæmias and morbid conditions of cutaneous glands; exudations.
Jewell, P. M., Ossian, Iowa.	Yes .....	Most forms of eczema .....
Beville, C., Winfield, Kansas.	Yes .....	All forms of eczema, lichen ruber, acne, purpura, vitiligo, all scaly diseases.
Free, Spencer M., Baltimore, Md.	No ..	Psoriasis .....
Pearson, Benj., Slippery Rock, Pa.	Yes .....	In eczema it is the sheet anchor.....
Strickler, O. C., New Ulm, Minn.	Generally.....	In all chronic stages of skin diseases....
Allen, H. C., Ann Arbor, Mich.	No .....	In those indicated by the similarity of the symptoms.
Campbell, E. N., Good Hope, Ill.	Yes .....	Acute and chronic eczema.....
Moore, W. G., St. Louis, Mo.	No.....	Chronic squamous diseases, as psoriasis, squamous eczema, etc.

IN SKIN DISEASES—*Continued.*

3.	4
.....	Arsenite of potash, arseniate of soda, arseniate of ammonia, arseniate of quinine, De Valangan's sol. and Donovan's sol., 5 drops Fowler's sol., or $\frac{1}{4}$ grain of arsenious acid.
Impairment of appetite.....	Fowler's and Donovan's solutions in minimum doses, long continued.
Conjunctivitis, vomiting, and diarrhœa.	Fowler's sol., 1 to 3 drops after each meal.
Severe symptoms of arsenical poisoning.	Fowler's solution, 3 to 5 drops.
None .....	Sol. sodii arseniatis; begin with small dose, increase rapidly until I get toxic symptoms, then revert to small dose ( $\frac{1}{10}$ – $\frac{1}{5}$ gr.).
Burning sensation in the stomach and urticaria.	Arseniate of potash and iodide of arsenic in small doses, long continued.
Erythematous eruption.....	Arsenious acid ( $\frac{1}{50}$ gr.) in pill form is combined with iron and strychnia.
Occasional puffiness of the face..	Fowler's solution, 3 to 10 drops t. i. d. after meals.
Temporary toxic effects.....	Fowler's solution, 2 to 8 drops after meals; occasionally Donovan's solution.
None ... ..	Arsenious acid, $\frac{1}{100}$ to $\frac{1}{25}$ gr. 3 times daily until suffusion of the conjunctiva occurs, reverting to smaller dose.
.....	Fowler's solution, 5 to 8 drops 3 times a day.
None .....	Fowler's solution, 5 to 10 drop doses.
Only temporary ill effects.....	Fowler's solution, 5 drops t. i. d. after meals; occasionally De Valangan's and Donovan's solutions.
None .....	Fowler's solution, iv. to xv. or xx. drops.
None .....	Fowler's solution, 5 drops, increasing to limit of toleration, 12 to 15 drops, t. i. d.
None ... ..	Fowler's solution, 3 to 10 drops after each meal.
Nausea with anorexia, inflammation of the skin with fine eruption, and burning and itching in one case.	Fowler's solution.
Pain in stomach, and vomiting..	Fowler's solution, 1 to 6 drops.
Aggravates acute eczema.....	Fowler's solution, 5 to 8 drops.
None .....	Arsenious acid.
None .....	Fowler's solution, 2 to 5 drops in chronic cases; 4 to 10 drops in acute cases.
Gastric disturbances and occasional aggravations of acute eruptions,	Fowler's solution in doses of 5 to 15 drops.

## Selection.

### EXCISION OF THE INITIAL LESION OF SYPHILIS.

DR. ZAREWICZ reports fourteen cases of excision of the primary chancre. The operation was performed in 1 case forty-eight hours after the appearance of the lesion; in 4 cases from six to ten hours; in 2, after twelve hours' time; in 1, after fourteen hours, and in 2 cases after 21 and 22 days.

The results were not very encouraging, to be sure, as in every case constitutional symptoms of the disease made their appearance, but the following reasons are given by the author for carrying out and advising the procedure:

1. By excision, the chancre is done away with quicker than by any other method, and the cure of the lesion is thus advantageously shortened. It sometimes happens that the induration returns in the cicatrix, but after this method it disappears more quickly than when the chancre has been treated in any other way.

2. The excision appears to modify the secondary symptoms.

3. Finally, we cannot deny the observations published by many physicians, even unicists, that in many cases positive results have been obtained by excision.

It appears that frequently the syphilitic poison does not advance rapidly in a centripetal direction, and in such cases the hard sore remains for a long time a local affection, and its excision under these circumstances can prevent general infection.—*Deutsch. Med. Zeit.*, July 29, 1886.

## Books and Journals Received.

Traité pratique et descriptif des Maladies de la Peau, par ALFRED HARDY, Professeur de clinique médicale à la Faculté de médecine de Paris, Médecin de l'hôpital de la Charité, etc. Paris, 1886. Librairie J. B. Baillière et Fils. 1 volume in 8° de 1,240 pages. Will be noticed in subsequent number.

The Pathology and Treatment of Syphilis and Allied Venereal Diseases, by HERMAN VON ZEISSL, M.D. Second edition. Revised by Maximillian von Zeissl, M.D. Translated with notes by H. Raphael, M.D. New York, D. Appleton & Co., 1866. Will be noticed in subsequent number.

An Abstract of Lectures on Leprosy, by J. L. BIDENKAP, with numerous chromo-lithographic plates. Christiania: Huschy & Co, 1886.

Teoryja Wsteczego Zarazenia Sie Matki Przymiotem od Plodu (Theorie "Choc en Retour"), by DR. KAROL SZADEK. Warszawa, 1886.

Leczenie Przymiotu, by DR. KAROL SZADEK. Warszawa, 1886.

Das Ol. Santali Ostindie als Antiblennorrhagicum, von DR. LETZEL. Reprint (*Allg. Med. Zeitung*).

Cas d'une Atrophie Idiopathique de la Peau par ALEXIS POSPELON. Reprint (*Annales de D. et S.*, Sept. 25, 1886).

Neuroses of the Genito-Urinary System, by L. BOLTON BANGS. Reprint.

Is Electrolysis a Failure in the Treatment of Urethral Strictures? By ROBERT NEUMAN, M.D. Reprint.

Analysis of 383 Cases of Skin Diseases Treated at the Military Hospital of Kien, with Cases, by CHARLES SCHADECK. Reprint.



Ein Fall ausgedehnter Acne Vulgaris, Complicirt durch Entzündliche Papillome. von CARL SCHADECK. Reprint.

Sulla Terapeutica Moderna delle Malattie della Pelle, pel PROF. COMM. CASIMIRO MANASSEI. Rome, 1886.

Sifilide Ereditaria, Discorso Inaugurale, pel PROF. COMM. CASIMIRO MANASSEI. Rome, 1885.

Ueber ein neues Endoskop, von DR. JOS. SCHÜTZ. Reprint (*Munch. Med. Wochenschrift*, 1886).

Ueber Calomelinjection zur Syphilisbehandlung, von PROF. DR. A. NEISSER. Reprint. Breslau, 1886.

Ueber Therapie der Syphilis, von PROF. DR. A. NEISSER. Reprint. 1886.

Ueber die Ansteckungsfähigkeit der chronischen Gonorrhoe. Reprint. 1886.

Demonstration von Leprazellen in Hautschnitten (in Bindegewebsspalten, Blutgefässen, Schweissdrüsen u. s. w.), von HERR TONTON.

The Hygiene of the Hair, by G. T. JACKSON, M.D.. Reprint. 1886.

Das Mollin, ein neues Seifenpräparat als Vehikel für die kutane Anwendung dermatologischer Medikamente, von TH. ALFRED KIRSTEN, of Leipzig. Reprint. 1886.

Mittheilungen aus der Strassburger Klinik für Syphilis und Hautkrankheiten, von DR. A. WOLFF und DR. J. NEGA. Reprint. 1886.

Vergleichende Untersuchungen über die Resorption und Wirkung verschiedener zur cutanen Behandlung verwandter Quecksilberpräparate, von DR. JULIUS NEGA, Strassburg, 1886.

Ueber die Beziehungen zwischen Stäbchen und Coccen, von DR. ADOLPH LUTZ. Reprint.

Das Ichthyol bei inneren Krankheiten, von DR. P. G. UNNA. Reprint.

Ueber Dünndarmpillen, von DR. P. G. UNNA. Reprint.

Clinical History and Treatment of Lichen Rubra, by DR. P. G. UNNA. Reprint.

## Item.

**THE ASSOCIATION OF GENITO-URINARY SURGEONS.**—In response to a circular letter from Dr. E. L. Keyes, addressed to a number of gentlemen in various parts of the United States interested in genito-urinary surgery and venereal diseases, the following gentlemen met at No. 1 Park avenue, Oct. 16, 1886. Drs. A. T. Cabot and F. B. Greenough, of Boston; Drs. E. L. Keyes, P. A. Morrow, and F. N. Otis, of New York; Dr. R. Park, of Buffalo; F. Rockwell, of Brooklyn, N. Y.; Drs. F. R. Sturgis and R. W. Taylor, of New York; and Dr. J. W. White, of Philadelphia. Telegrams and letters expressing regret at inability to attend were read from Drs. Brinton, Bryson, Garnett, Greenway, Gross, Hingston, Hyde, Masten, and others. Dr. Keyes was chosen temporary chairman, and Dr. Taylor, temporary secretary. The meeting then discussed the various matters incident to the formation of a scientific association. It was voted that a committee be appointed with power to draft a constitution and by-laws, and make arrangements for a future meeting. The Committee of Organization consists of the following gentlemen: Chairman, Dr. Keyes; Secretary, Dr. Taylor; Drs. Sturgis, C. M. Masten, A. T. Cabot, J. W. White, and J. N. Hyde,

## Editorial.

---

### THE JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

WITH the completion of the fourth volume of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, the title will be changed to that of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

This change is made with the view of broadening the scope of the Journal, so as to embrace the consideration of a large class of genito-urinary diseases of great interest to the general practitioner as well as to the specialist, which, because not strictly venereal, have been excluded from its pages. We feel assured that the introduction of this new feature will add very materially to the interest as well as the practical usefulness of the Journal.

The recent organization of the Association of Genito-Urinary Surgeons will doubtless give a fresh impetus to the study of genito-urinary diseases and syphilis in this country. We shall be pleased to bring before the profession the results of the work of this association in these special departments. We have already secured the promise of contributions from some of its leading representatives, and hope to secure the support of others.

The ever-increasing growth of our knowledge of the diseases to the consideration of which this Journal is specially devoted, renders it indispensable to every physician who wishes to keep up with the advances made in dermatological and genito-urinary practice. No effort will be spared to maintain the high character which the Journal has already achieved for scientific excellence and practical value. The wants of the general practitioner will be especially considered. The foreign correspondence from representative men, which has formed such a distinctive and valuable feature, will be continued with an enlarged corps of contributors.

With the beginning of the new volume, the size of the Journal will be increased by the addition of eight pages of reading matter. It will be still further enlarged should the demands upon our space render it necessary.

# INDEX.

---

- A case of dysidrosis of the face (with plate). George Thomas Jackson, 1
- A case of "rupia syphilitica," confined almost exclusively to one side of the body. J. P. Knoche, M.D., 36
- A case of iodic purpura. Etienne C. Vidal, M.D., 81
- A contribution to our knowledge of the hydroa bulleux of Bazin, and of the dermatitis herpetiformis of Duhring. R. W. Taylor, M.D., 106
- A contribution to the clinical study of scleroderma. J. E. Graham, M.D., 332
- A remarkable neoplasm of the skin (illus.). James H. Dunn, M.D., 129
- An additional note on double comedo. A. H. Ohlmann-Dumesnil, A.M., M.D., 193
- Abortive treatment of urethritis, 125
- Abortion of small-pox, 63
- Absorption of fatty substances, 254
- Action of mercury on the blood, 128
- Adulteration of cubebs, 124
- ALLEN. Recent progress in the treatment of chancroid, 40
- Dermatoses of the eye, 167, 201
- Molloscum contagiosum, analysis of 50 cases, 238
- Alopecia areata treated by static electricity. Fox, 46
- American Dermatological Association, 256, 320
- Dermatological Association, transactions of, 304
- Anæsthesia of skin from mercurial poisoning, 217
- Annual meeting of the New York Dermatological Society, 224
- Application for warts, 255
- Arsenical eruptions. Prince A. Morrow, A.M., M.D., 195
- eruption. Morrow, 178
- Arsenic in skin diseases (editorial), 218
- Association of genito-urinary surgeons, 379
- ATKINSON. Scarlatina and scarlatiniform eruptions following injuries and operations, 295
- Baldness, prescription for, 32
- Broken glass in the vagina, 192
- BULKLEY. On the existence of dermatitis herpetiformis as a distinct disease, 111
- Can a man have a female complaint, 320
- Carcinoma of the skin. Denslow, 309
- Case of tylosis (callositas) of the hands (with plate). Robert B. Morrison, M.D., 5
- of erythema venenatum. Frederick W. Putnam, M.D., 142
- of acquired syphilis. Keyes, 22
- of epithelioma of the face. Lewis, 338
- of lichen planus. Robinson, 20
- of mycosis fungoide, with autopsy. Fox, 305
- Chancre of the conjunctival cul-de-sac, 224
- Chloride of calcium in scrofulous affections, 224
- Chondroma of the lip. Robinson, 308
- Chromidrosis or chromocrinia, 60
- Chronic œdema of the lids and eczema of the nose, 244
- Chrysophanic acid in treatment of psoriasis, 24
- Cirrhosis of the liver, 144
- Clinical notes on the value of resorcin, ichthyol, and lanolin in cutaneous diseases. Henry W. Stelwagon, M.D., etc., 326
- notes on scabies. Greenough, 307
- study of molluscum pendulosum, 318
- Cocaine in mercurial stomatitis, 190
- and boric acid in gonorrhœa, 255
- in herpes zoster, 255
- Collodion in variolous eruptions, 352
- Colloid degeneration of the derma, 52
- Comedo extractor (illus.). Piffard, 23

- Contagious diseases\*of the scalp in children, 25
- Contagiousness of variola at the beginning of the eruption, 62
- Copaiba suppositories in vaginitis, 160
- CORLETT. Diseases of the skin in the subjects of gout, 265
- CORRESPONDENCE. Dermatology and syphilography in France. Brocq, 23, 46, 149, 244, 311
- Dermatology and syphilography in Great Britain. Cavafy, 182, 208, 279
- BALDWIN. The use of arsenic in skin diseases, 345
- BLYTHE. Treatment of winter itch, 276
- ESCH. Treatment of rhus poisoning, 207
- FAITHFUL. Arsenic in skin diseases, 371
- FARNHAM. Arsenic in skin diseases, 372
- MCGUIRE. Treatment of pruritus and rhus poisoning, 276
- MEDICUS. A personal case of psoriasis—ill effects of arsenic, 277
- PREBLE. Brown discoloration from repeated exposure to sulphur-vapor instantly removed by hydrogen peroxide, 207
- REGENSBURGER. Treatment of rhus poisoning, 244
- REID. Treatment of rhus poisoning, 345
- SHERBURNE. A "troublesome cutaneous disease," 205
- TOMPKINS. The treatment of rhus poisoning, 180
- VIDAL. Molluscum contagiosum, 345
- WHITE. Treatment of rhus poisoning, 207
- ZEISLER et al. Arsenic in skin diseases, 372-377
- Dermatitis herpetiformis. Bronson, 340
- herpetiformis. Bulkley, 84
- Dermatoses of the eye. Chas. W. Allen, M.D., 167, 201
- Diagnosis of small-pox. Prince A. Morrow, A.M., M.D., 72
- between the initial sclerosis of syphilis and local contagious helcose, 350
- of gonorrhœa in the female, 64
- of chancre and herpes, 26
- Differential diagnosis of syphilis and scrofula, 155
- "Diphtheroid chancre." Taylor, 342
- Diseases of the skin in the subjects of gout. A report of three cases; with remarks. William T. Corlett, M.D. L.R.C.P., London, 265
- Double comedo, due to a hitherto undescribed anomaly of the sebaceous ducts (illus.). A. H. Ohmann-Dumesnil, A.M., M.D., 33
- Dressing of contused wounds with decoction of valerian root, 63
- DUNN. A remarkable neoplasm of the skin, 129
- Early gonorrhœa, 192
- Eczema of the anus, 245
- of the hairy scalp, 223
- in the gouty, 149
- of the nares, 316
- Electric light for skin examination. Piffard, 122
- Electrotherapy in angioneurotic bullous exanthem, 317
- Elephantiasis arabum in children, 273
- Empyreumatic oil of the yellow of eggs as a dressing, 319
- Epididymitis, 223
- Epithelioma. Bulkley, 343
- Eruption of herpes zoster during the employment of arsenic, 217
- Erythema syphiliticum. Bronson, 304
- Excision of the initial lesion of syphilis, 378
- Four cases of late syphilitic lesions of the rectum. R. W. Taylor, M.D., 225
- FOX. The value of lanolin, 165
- Furunculosis, 47
- Gangrene of the penis, 190
- caused by iodine collodion, 179
- Generalized erythematous exfoliative dermatitis, 48
- General alopecia following keratosis. Fox, 84
- General chromophytosis. Jackson, 143
- Glycerole for cutaneous pruritus, 255
- Gonorrhœal warts, 192
- Gonorrhœa, syphilis, 92
- from male to male, 359
- GOTTHEIL. Notes on a case of lichen scrofulosus, 133
- GRAHAM. Contribution to the clinical study of scleroderma, 332
- Hamamelis virginica in the treatment of prostatic disease, and of buccal cancer, 31
- HARDAWAY. Exfoliative dermatitis with bullous lesions, 330
- Inflammation of the hair follicles within the nares, 360
- The question of the value of arsenic in diseases of the skin, 233



- Hard chancre of the vagina, 349  
 Hemorrhages in syphilis, 159  
 Herpes following the external use of belladonna and atropine, 32  
 Homœopathic treatment of rhus poisoning, 351  
 Horny growth at the extremity of the penis, 192  
 HYDE. Bullous eruption caused by ingestion of iodide of potassium, 383  
 Hydroa bulleux and kindred affections. Taylor, 85  
 Hyperidrosis, 32, 183  
 Ichthyol in sheets, 191  
   and resorcin, 282  
 Impetigo; its contagious and parasitic nature, 46  
 Impotence, 96  
 Incontinence of urine, 320  
 Infantile eczema, 32  
 Influence of mercury in delaying symptoms and as an antidote in syphilis, 211  
 Internal administration of chrysarobin in eczema and impetigo of children, 126  
 Intra-muscular injections of metallic mercury in syphilis, 30  
 Iodoform in venereal diseases, 126  
 Iodol, a substitute for iodoform, 224  
 Joiners' varnish in burns and scalds, 191  
 Keloid, a case of, having several points of interest. Piffard, 85  
 Keratosis follicularis. Morrow, 83  
   of the nails. Robinson, 146  
   follicularis, associated with fissuring of the tongue and leukoplakia buccalis (illustrated). Prince A. Morrow, A.M., M.D., 257  
 KEYES. The useful administration of arsenic in diseases of the skin, 230  
 KINNIER. Lanolin, 270  
 KNOCHE. *Rupia syphilitica*, 36  
 Lanolin. D. F. Kinnier, M.D., 270  
 Latent syphilis, a case. E. R. Palmer, M.D., 274  
 Late hereditary syphilis. Fournier, 311  
 Lepra tuberosa, 319  
 Leprosy in Norway, 23  
 Lesions of the buccal mucous membrane in lichen planus, 51  
 Leucoderma or vitiligo. J. A. Wessinger, M.D., 174  
   syphiliticum, 158  
 Lichen and its treatment, 246  
   planus. Bulkley, 339  
 Little learning a dangerous thing, 96  
 Local baths of corrosive sublimate in the treatment of certain syphilides, 349  
   treatment of the cutaneous lesions of syphilis, 127  
 Lotions of sulphide of potassium, 32  
 Lupus treated with cold, 30  
   of the larynx. Sherwell, 146  
 Macular leprosy. Fox, 176  
 Melanosis often not black; melanotic whitlow, 188  
 Metallic mercury in syphilis, 30  
 Mercurial stomatitis. Campbell, 143  
 Microbe of syphilis, 285  
 Micrococcus of vaginitis in children, 39  
 Micrococci of alopecia areata, 64  
 Moles, relative frequency and pathological significance. Sherwell, 309  
 Molluscum contagiosum—an analysis of fifty cases (illustrated). Charles W. Allen, M.D., 238  
 MORROW. On the diagnosis of small-pox, 72  
   the bullous form of iodic eruption, 97, 136  
   arsenical eruptions, 195  
   keratosis follicularis, with fissuring of the tongue and leukoplakia buccalis, 257  
   report of a case of favus, with remarks on treatment of tineas, 321  
 Multiple xanthoma, 209  
 Native plants injurious to the skin. White, 308  
 Nature of the chancroidal bubo, 50  
 New deodorizer, 224  
 Nerve nævus. Robinson, 147  
 Nervous troubles in slow mercurial intoxication, 93  
 New excipient for mercurial ointment, 32  
 Non-venereal syphilis. Sherwell, 84  
 Non-virulent ulcerations of the genitals, 347  
 Notes on a case of lichen scrofulosus. Wm. S. Gottheil, M.D. (illustrated), 133  
   on drugs. Henry G. Piffard, M.D., 293  
   of a case of exfoliative dermatitis (pityriasis rubra?) with bullous lesions. W. A. Hardaway, M.D., etc., 330  
 Observations on eczema, 58  
 OHMANN-DUMESNIL. Double comedo from anomaly of the sebaceous ducts, 33  
   additional note on double comedo, 193

- Ointment for syphilitic psoriasis, 160  
 On some of the uses of pyrogallic acid in dermatology, and the dangers attending its application. Allen, 44  
   the existence of "dermatitis herpetiformis" (of Duhring) as a distinct disease. L. Duncan Bulkley, A.M., M.D., 111  
 OTIS. On the limitation of the contagious stage of syphilis in relation to marriage, 65, 101  
 Oral speculum. Taylor, 344.
- PALMER. Latent syphilis, a case, 114  
 Papilloma of the forearm. Fox, 83  
 Parasitic skin diseases, 320  
 Pathogeny of herpes phlyctænoides, 157  
 Peculiar case of discoloration of the skin in a patient suffering from cirrhosis of liver. Taylor, 144  
 Pemphigus, 183  
   followed by albuminuria. R. H. Sabin, M.D., 172  
 Perforating ulcer of the hand, 62  
 Phimosis, 192  
 Photography made easy. Piffard, 85  
 PIFFARD. Notes on Drugs, 293  
 Pityriasis rubra. Sherwell, 344.  
   rubra, with vesicular lesions. Morrow, 176  
 Poison ivy eruption, 160  
 Polymorphous erythema, 285  
 Precocious gummata. Taylor, 306  
 Prevention of gonorrhœa, 94  
 Probable tuberculosis of the skin. Tilden, 310  
 Professional dermatoses, 29  
 Pruritus of diabetes, 64  
   vulvæ, 96  
 Psoriasis, notes on. Greenough, 308  
   treated with pyrogallic acid. Allen, 44  
 Purpura, 182  
 PUTNAM. Case of erythema venenatum, 142
- Quinine in skin affections, 64  
   eruptions, 183
- Rare malformation of the urethra, 125  
 Raynaud's disease, 184  
 RECEIVED, books and pamphlets, 95, 160, 223, 288, 378  
 Recent progress in the treatment of chancroid. Chas. W. Allen, M.D., 40  
 Recovery from malignant pustule, 280  
 Recurrent scarlatiniform erythema, 48  
 Relations between lupus and tuberculosis, 311  
 Report of a case of favus (tinea favosa), with remarks on the treatment of the tinea (with plate). Prince A. Morrow, A.M., M.D., 321  
 Resorcin, 252  
 Re-urrection of blennorrhagia, and the value as a parasiticide of corrosive sublimate injections, 50  
 Retraction of the penis, 190  
 REVIEWS. BULKLEY. Acne: its etiology, pathology, and treatment, 27  
   BELFIELD. Diseases of the urinary and male sexual organs, 123  
   FAGGE. The principles and practice of medicine, etc. Including: a section on cutaneous diseases, by P. H. Pye-Smith, M.D.; chapters on cardiac diseases, by Sam'l Wilkes, M.D., etc., 222  
   HILL and COOPER. The student's manual of venereal diseases, 191  
   LESSER. Lehrbuch der Haut- und Geschlechtskrankheiten, 220  
   MORROW. Venereal memoranda: a manual for students and practitioners, 94  
   PERRIN. De la sarcomatose cutanée, 221  
   PIFFARD. Cutaneous memoranda, 123  
   Transactions of the Academy of Medicine in Ireland, vol. III. Edited by Wm. Thompson, M.A., F.R.C.S., 94  
 Rheumatic purpura, 189  
 Rhinoscleroma, 209  
 Rickets and hereditary syphilis, 153  
 Ringworm, 210  
 Rosacea hypertrophica. Jackson, 82  
 Rubella or rôtheln. Atkinson, 305
- SABIN. Pemphigus followed by albuminuria, 172  
 Scabies, 223  
 Scarlatina and scarlatiniform eruptions following injuries and operations. I. E. Atkinson, M.D., etc., 295  
 Scientific inquiry, 320  
 Scleroderma, 208  
 Sclerosis of the external female genital organs, 189  
 Simple papillomata, 294  
 Solution for vulvar syphilides, 255  
 Some moot points in the natural history of syphilis, 85  
   of the uses of pyrogallic acid in dermatology, and the dangers attending its application (illus.). Charles W. Allen, M.D., 8  
   remarks on the diagnosis and treatment of spasmodic stricture. John Blake White, M.D., 161

- Squamous roseola in its varied forms, 189
- STELWAGON. Resorcin, ichthyol, and lanolin in cutaneous diseases, 326
- Study of genital herpes in man and in woman, 93
- Symmetrical gangrene and local asphyxia, 287
- Syphilis, 210  
     conveyed by vaccination with clear lymph, 92  
     of the brain, 128  
     of the inferior maxilla, 286  
     of the placenta, 275  
     from tattooing, 128  
     treated with the tannate of mercury, 281
- Syphilitic bubo, 127  
     stricture of the trachea, 56  
     epilepsy and its differential diagnosis from ordinary epilepsy, 317
- TAYLOR. Contribution to our knowledge of hydroa bulleux, etc., 106  
     The hydroa bulleux of Bazin and dermatitis herpetiformis of Dühring, 120  
     Four cases of late syphilitic lesions of the rectum, 225
- Theory of syphilitic infection of mother by the foetus, 352
- Therapeutics of syphilis, 249
- Therapeutical use of lanolin, 127  
     action of alveloz, 351
- TILDEN. Trophoneurosis of the skin from injury to the median nerve, 289
- Toxic properties of naphthol and the treatment of scabies by that substance, 25
- To stop falling of the hair after typhoid fever, 320
- Topical applications in diseases of the skin, 279
- Trophoneurosis of the skin caused by injury to the median nerve. G. H. Tilden, M.D., 289
- The question of the value of arsenic in diseases of the skin. W. A. Hardaway, A. M., M.D., 233  
     useful administration of arsenic in diseases of the skin. Edward L. Keyes, M.D., 230  
     bullous form of iodic eruption (with plate). Prince A. Morrow, A.M., M.D., 97, 136  
     value of lanolin. George Henry Fox, A.M., M.D., 163  
     significance and diagnosis of gonorrhoea in the female, 28  
     limitation of the contagious stage of syphilis, especially in its relations to marriage. Fessenden N. Otis, M.D., 65, 101
- The surgical treatment of chronic eczema, 53  
     internal treatment of gonorrhoea, 315  
     value of arsenic in skin diseases. Fox, 179  
     contagium of syphilis, 153  
     leprosy bacillus, 280  
     removal of superfluous hairs by electrolysis, 279  
     pathogeny of dermatoses, 148  
     local treatment of psoriasis by chrysophanic acid, 59
- TRANSACTIONS of the New York Dermatological Society, 20, 44, 82, 120, 143, 176, 338, 365  
     of the American Dermatological Association, 304
- Treatment of acne by the use of sounds, 310  
     of alopecia, 320  
     of angioma, 126  
     of chancroidal and syphilitic phagedenism, 51  
     of chancroid, 26  
     of chronic urticaria, 232  
     of eczema, 62  
     of freckles with carbolic acid, 64  
     of furuncles, 96  
     of gonorrhoeal hæmaturia, 224  
     of gonorrhoea with antiseptic injections, 152  
     of itch, 96  
     of keloid, 49  
     of lupus, 281  
     of lupus by arsenic, 63  
     of lupus vulgaris, 312  
     of lupus erythematosus, 312  
     of erythematous lupus by the application of a mixture of vinegar and yellow of an egg, 256  
     of psoriasis, 64, 248  
     of psoriasis with chrysophanic acid, 150  
     of melanodermata, 314  
     of rhus poisoning, 180, 207, 208, 244, 276, 345  
     of scrofulous diathesis, 61  
     of superficial epithelioma, 314  
     of syphilis by subcutaneous injections of oxide of mercury, 128  
     of syphilitic phagedenism, 314  
     of pigment spots of the skin, 216  
     of tinea tonsurans by the method of Follis, 49
- Tuberculosis verrucosa cutis, 156
- Turpentine in malignant tumors, 96
- Unique mode of contagion in gonorrhoea, 31
- Urethral injections in gonorrhoea, 185

- Urticaria eruption due to iodide of potassium. Taylor, 341  
pigmentosum, 51, 253
- Vegetating syphiloderma of the face. Allen, 147
- VIDAL. A case of iodic purpura, 81
- Vulvar pruritus, 151
- WESSINGER. Leucoderma or vitiligo, 174
- WHITE. Remarks on the diagnosis and treatment of spasmodic stricture, 161  
White clay in epididymitis, 256
- Xeroderma pigmentosum, 60
- Zinc oxide in the treatment of chronic specific urethritis, 318
- Zoster fever, infectious zona, 159









Annex

Ann.



## COLUMBIA UNIVERSITY LIBRARIES

This book is due on the date indicated below, or at the expiration of a definite period after the date of borrowing, as provided by the library rules or by special arrangement with the Librarian in charge.

[illegible]

